

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06975

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06966

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewood</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Abingdon</i>	
c. LENGTH OF STAY IN 1b <i>2 weeks</i>		d. STREET ADDRESS <i>Route #2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Outer Point Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles C. Addison</i>		First <i>Charles</i>	Middle <i>C.</i>
4. DATE OF DEATH <i>May 17 1966</i>		Last <i>Addison</i>	Month <i>May</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>3 Jan. 1889</i>		9. AGE (In years last birthday) <i>77 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer (Ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sawmill-Gas Station</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Theodore Addison</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>217-01-3950-A</i>		17. INFORMANT <i>Hannah E. Addison, Abingdon, Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-sclerotic CVD Disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
4221 Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Baltimore</i> (County) <i>Md.</i> (State) <i>Md.</i>		20g. (City or town) <i>Baltimore</i> (County) <i>Md.</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Gerald E. Palmer</i>		22. DATE SIGNED <i>5-17-66</i>	
EXAMINER'S NAME (Type) <i>Gerald E. Palmer</i>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>20 May 66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Bel Air Memorial Gardens, Bel Air Md.</i>
24. FUNERAL DIRECTOR <i>Tarring Funeral Home</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE
25c. DATE <i>MAY 19 1966</i>			

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✓ Ward 9 Merrill
(1919 5 10) (2)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
HARFORD		a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY <i>HARFORD</i>	
<i>Havre de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <i>DoA.</i>		d. STREET ADDRESS <i>632 Chapel Terrace</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>HARFORD MEMORIAL HOSPITAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
99			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>WILLIAM PAUL ANDERSON</i>		Last	
4. DATE OF DEATH		Month	Day
<i>MAY 16 1966</i>		Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<i>Male</i>		<i>W</i>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
<i>Mar. 13, 1925</i>		<i>41 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)
<i>Writer</i>		<i>Edgewood Arsenal</i>	<i>Chesa. Va.</i>
12. CITIZEN OF WHAT COUNTRY?		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>James Anderson</i>		<i>Martha Offerer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
<i>Yes</i>		<i>233-34-5782</i>	<i>Mrs. Edith C. Anderson</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address <i>632 Chapel Terrace</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Myocardial infarction</i>	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	<i>A. C. V. D</i>
		DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Jan 1966</i>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1966</i> to <i>MAY 16, 1966</i> , that (I) (we) last saw the deceased alive on <i>April 12, 1966</i> , and that death occurred at <i>9:00 A.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>John D. Yur</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN D. YUR</i>		22d. ADDRESS <i>Havre de Grace</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 19, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cemetery</i>		23d. LOCATION (City, town or county) <i>Arlington</i>	
24. FUNERAL DIRECTOR <i>R. Madison Mitchell, Havre de Grace Md.</i>		25a. ADDRESS <i>Havre de Grace Md.</i>	25b. REC'D BY REGISTRAR <i>MAY 18 1966</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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1230

age: 81 yrs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
06977				06968									
1. PLACE OF DEATH		a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		a. STATE			
		HARFORD		BEL AIR		MARYLAND		MARYLAND		HARFORD			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		120 MAULSBY AVE		22 yrs.		BEL AIR		BEL AIR		12-1			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year			
ARCHER						AYRES		May 10		1966			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IS RESIDENCE ON A FARM?			
MALE		WHITE		WIDWED <input type="checkbox"/> DIVDRCD <input type="checkbox"/>		MARCH 31-1980		86 yrs.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
LABORER		STATE ROAD		ROCKS, MARYLAND		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		LARA HARMON		120 Address MAULSBY AVE							
JAMES AYRES		ANNIE B. AYRES		BEL AIR, MD									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
NO		312-22-3196		ANNIE B. AYRES		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease							
4221		DUE TO		(b)									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
				Hour a.m. p.m. 19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (the hospital) attended the deceased from 1-1, 1963, to 5-10, 1966, that (II) (we) last saw the deceased alive on 5-2 1966, and that death occurred at 730 M, from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED		Gerald C Palmer		M.D. ATTENDING PHYS.		M.O. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		5-10 66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		Gerald C Palmer		Bel Air, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		Gooptown MARYLAND	
Burial		5/12/1966		WILLIAM WATTERS				MAY 11 1966				Charles Judge	
24. FUNERAL DIRECTOR		ADDRESS											
Charles E. Kurtz Jarrettsville, Md													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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06978 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06969

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen PG, Md.		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kirk Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Regina	First Regina	Middle Agnes	Last Bahel
4. DATE OF DEATH DF Month May	Day 9	Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 26 Nov 1884
			9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles B. Miller	14. MOTHER'S MAIDEN NAME Leah J. Cloman	Address 214 Edmund St. Aberdeen, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-54-7708 T	17. INFORMANT Mrs. Margaret M. Hartig,	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
4200 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		DUE TO INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1220M (County) Harford (State) Maryland
21. I certify that (I) Harold C. Sheaffer attended the deceased from 4 May 1966 to 9 May 1966 , that (I) Harold C. Sheaffer last saw the deceased alive on 9 May 1966 , and that death occurred at 1220M , from the causes and on the date stated above.			
22a. SIGNATURE <i>Harold C. Sheaffer</i>		22b. DATE SIGNED 9 May 1966	
22c. PHYSICIAN'S NAME (Type) Harold C. SHEAFFER, Capt., MC	22d. ADDRESS Kirk Army Hospital, Aberdeen PG, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12 May 66	23c. NAME OF CEMETERY OR CREMATORIAL Harford Memorial Gardens, Aberdeen, Maryland	23d. LOCATION (City, town or county) (State) Aberdeen, Maryland
24. FUNERAL DIRECTOR Walter MacCullum Jr.	Tarring Funeral Home	25a. REC'D BY REGISTRAR MAY 12 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
25		25	
VR A15 (4) 15M 4-64		25	

July 23, 1968

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06979

06970

1. PLACE OF DEATH a. COUNTY <i>Harford</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>MD</i>	b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harve de Grace</i>	c. LENGTH OF STAY IN 1b <i>5 days</i>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>RFD</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>	d. STREET ADDRESS <i>12-1</i>	d. STREET ADDRESS <i>12-1</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sarah</i>	First <i>Elizabeth</i>	Middle <i>Baker</i>	4. DATE OF DEATH Month <i>May</i> Day <i>30</i> Year <i>1966</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>18 June 1884</i>	9. AGE (In years last birthday) <i>81</i> yrs.	10. UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	11. UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Harford County, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Jackson B. Flowers</i>	14. MOTHER'S MAIDEN NAME <i>Lydia Fantom</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>214-12-4063-A</i>	17. INFORMANT <i>John T. Baker, Aberdeen, Md.</i>	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH <i>3 day</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arachel Henwesage.</i>						<i>Arachel Henwesage.</i>
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Arteur's clastic CV Disease</i>						<i>Arteur's clastic CV Disease</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Churchville</i>	(County) <i>Maryland</i>	(State) <i>MD</i>
21. I certify that (I) (this hospital) attended the deceased from <i>5-26</i> , 19 <i>66</i> to <i>5-30</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5-30 1966</i> , and that death occurred at <i>12</i> M, from the causes and on the date stated above.						22b. DATE SIGNED <i>7/31/66</i>
22a. SIGNATURE <i>Joseph Horky</i>						22b. DATE SIGNED <i>7/31/66</i>
22c. PHYSICIAN'S NAME (Type) <i>J. Ralph Horky, MD</i>						22d. ADDRESS <i>Churchville, Maryland</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12 June 66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Zion Cemetery</i>	23d. LOCATION (City, town or county) <i>Bel Air, Maryland</i>	(State) <i>MD</i>		
24. FUNERAL DIRECTOR <i>John G. Tarring</i>	25a. REC'D BY REGISTRAR <i>JUN 3 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

Q523

10.000 m², 61

1000 m², 1000 m²

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
• COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Aberdeen Proving Ground

c. LENGTH OF STAY IN 1b

13 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Kirk Army Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

23 May 06

9. AGE (In years
last birthday)

59

yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY

Security Guard

US Army

New York, Corinth

USA

13. FATHER'S NAME

Thomas

Bennett

14. MOTHER'S MAIDEN NAME

Mar - Mae

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

20 years service 058302890

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mildred D. Bennett

Boy 106 B.
Darlington, Md.

Wife

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

Myocardial infarction

INTERVAL BETWEEN
ONSET AND DEATH

4201

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

Myocardial infarction

13 days

DUE TO

(c)

Atherosclerotic heart disease

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m.

20d. INJURY OCCURRED

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (1) (this hospital) attended the deceased from.....

8/11/66 to 7/11/66, 1966, that (1) (we) last

saw the deceased alive on 21 May 1966, and that death occurred at..... M, from the causes and on the date stated above.

22a. SIGNATURE

Peter Giustra

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

X

21 May 66

22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

PETER GIUSTRA, CAPT., MC

22d. ADDRESS

KAH, APG, Md.

23a. BURIAL, CREMATION
REMOVAL (Specify)

23b. DATE THEREOF

5/17/66

23c. NAME OF CEMETERY OR CREMATORIUM

Arlington Nat.

23d. LOCATION (City, town or county)

Arlington Va.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Gennings & Son

DATE

27

NAME BY REGISTRAR

Charles Judge

REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE M
HEALTH DEPT.

06981

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06972

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. One copy along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <i>Harford</i> MARYLAND		a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Falls</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyde</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Samuel Brown Road</i>		d. STREET ADDRESS <i>R D</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Walter</i>		First	Middle
		Last	
4. DATE OF DEATH <i>Boyd</i>		Month <i>May</i>	Day <i>18</i>
		Year <i>1966</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <i>7-1-15</i>		9. AGE (In years last birthday) <i>50</i> yrs.	10. IF UNOER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plaster</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Local 96</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Co. Maryland</i>
13. FATHER'S NAME <i>Walter R. Bond</i>		14. MOTHER'S MAIDEN NAME <i>Christine Bay</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-0708949</i>	17. INFORMANT <i>Mrs Ethel Bond Harford Road Hyde, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>coronary occlusion</i>	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { lost. (b) DUE TO (c) DUE TO (d) DUE TO (e) DUE TO (f) DUE TO (g) DUE TO (h) DUE TO (i) DUE TO (j) DUE TO (k) DUE TO (l) DUE TO (m) DUE TO (n) DUE TO (o) DUE TO (p) DUE TO (q) DUE TO (r) DUE TO (s) DUE TO (t) DUE TO (u) DUE TO (v) DUE TO (w) DUE TO (x) DUE TO (y) DUE TO (z)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bel Air</i>
20f. (City or town) <i>Bel Air</i>		(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>5-18-66</i>	
ACTUAL SIGNATURE <i>Gerald E. Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <i>5-18-66</i>
EXAMINER'S NAME (Type) <i>Gerald E. Palmer MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
		Address (Street, city, town, or county) <i>Bel Air, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-21-1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Memorial Cemetery</i>
23d. LOCATION (City or Town) <i>Bel Air</i>		(County) <i>Md.</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Loewenthal Funeral Home 7401 Belair Road</i>		ADDRESS <i>1361</i>	25a. REC'D BY REGISTRAR <i>MAY 23 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M 0682 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 06973

1. PLACE OF DEATH
a. COUNTY

HARFORD

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Aberdeen Proving Ground

c. LENGTH OF STAY IN 1b

1 day

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

HARFORD

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Aberdeen Proving Ground

12 - 1

d. STREET ADDRESS

2737 G Watervliet

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First
Infant Male

Middle

Last

4. DATE
OF
DEATH

Month
May

Day
31

Year
1966

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

31 May 66

9. AGE (In years
last birthday)

yrs.
N/A

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

N/A

10b. KIND OF BUSINESS OR
INDUSTRY

N/A

11. BIRTHPLACE (County & State, or foreign country)

Harford, Maryland

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

Wardell Burroughs

14. MOTHER'S MAIDEN NAME

Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

N/A

17. INFORMANT

Barbara Burroughs

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Prematurity

INTERVAL BETWEEN
ONSET AND DEATH
2 hours

776 X

DEUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1703 31 May 1966, to 1905 31 May 1966 that (I) (we) last
saw the deceased alive on 31 May 1966, and that death occurred at 1905 M, from the causes and on the date stated above.

22a. SIGNATURE

Bradley Barnes Capt. M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE SIGNED

5/ May 66

22c. PHYSICIAN'S
NAME (Type)

BRADLEY T BARNES Capt. MC

22d. ADDRESS

Kirk Army Hospital APG, Md

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

16/2/1966

23b. DATE THEREOF

APG Post Cemetery

23d. LOCATION (City, town or county)

Aberdeen Proving Ground Md

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

JUN 6

1966

DATE

25b. REGISTRAR'S SIGNATURE

Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06983

CERTIFICATE OF DEATH

06974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		b. COUNTY Harford	
c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital		d. STREET ADDRESS 320 So. Philadelphia Ave. Blvd.	
12-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rex Allen		4. DATE OF DEATH Month Day Year May 3 1966	
5. SEX Male		6. COLOR OR RACE Cau	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3 May 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Aberdeen Proving Gr., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Danny H. CATRON		14. MOTHER'S MAIDEN NAME Debbie KEESYMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Father, same as 2 C & D		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DUE TO caused by (d) (e) (f)		INTERVAL BETWEEN ONSET AND DEATH From birth	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 May 1966, to 3 May 1966, that (I) (we) last saw the deceased alive on 3 May 1966, and that death occurred at 6:15 PM from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Robert Wright Jr.		22b. DATE SIGNED 3 May 66	
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Aberdeen Proving Ground, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6 May 66	
23c. NAME OF CEMETERY OR CREMATORIAL A.P.G. Post Cemetery		23d. LOCATION (City, town or county) Aberdeen Proving Ground	
24. FUNERAL DIRECTOR'S SIGNATURE Tarring & Funeral Home Aberdeen, Maryland		25a. REC'D BY REGISTRAR MAY 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

nelia

25

CERTIFICATE OF DEATH

06975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in the event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Harford MARYLAND		Maryland Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural) 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #1		d. STREET ADDRESS Route #1, Box 151-A	
3. NAME OF DECEASED (Type or print)		First <i>Blanche</i>	Middle <i>May</i>
4. DATE OF DEATH		Month <i>May</i>	Day <i>13</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female Cau.		WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR IF UND 24 HRS
29 July 1889		76 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert F. Cullum		14. MOTHER'S MAIDEN NAME Maggie May Homer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-01-2310	
17. INFORMANT No		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>Diabetes mellitus</i>	
DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Urinary tract infection</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5-13-1966</i> to <i>5-13-1966</i> , that (I) (we) last saw the deceased alive on <i>5-13-1966</i> , and that death occurred at <i>Aberdeen</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>5-13-66</i>	
22a. SIGNATURE <i>P. R. Cullum</i>		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Peter P. Roodman</i>		22d. ADDRESS <i>Aberdeen Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 15 May 66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State) Wesleyan Chapel Cemetery, Aberdeen, Maryland	
24. FUNERAL DIRECTOR <i>W. L. Roodman Jr.</i>		25a. REC'D BY REGISTRAR MAY 17 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M 06985

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06976

1. PLACE OF DEATH a. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Havre de Grace		c. LENGTH OF STAY IN 1b 8 weeks		a. STATE Md		b. COUNTY Harford	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Hartford Memorial				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Forest Hill	
d. STREET ADDRESS		Route #1, Box 49		12-1		e. IS RESIDENCE ON A FARM?		Boggs Grove	
e. IS RESIDENCE ON A FARM?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. MIN.
F		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 13, 1917	49 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		none		Clover, S.C.		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Unknown		Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		216-38-4274		Grant A. Eller, Forest Hill, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		416X		Chronic Cardiac DeCompensation					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		Old rheumatic heart disease					
		DUE TO (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BelAir, Harford		(County) Md.	
19								(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from <u>March 20, 1966</u> , to <u>May 17, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 14th, 1966</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE		<u>Edward C. Loo</u>		22b. DATE SIGNED 5/15/66					
22c. PHYSICIAN'S NAME (Type)		Edward C. Loo, M.D.		22d. ADDRESS Havre de Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Burial May 17, 1966		23c. NAME OF CEMETERY OR CREMATORIAL BelAir Memorial Gardens		23d. LOCATION (City, town or county) BelAir, Harford		(State) Md.	
24. FUNERAL DIRECTOR		ADDRESS Howard K. McComas & Son, Abingdon, Md.				25a. REC'D BY REGISTRAR MAY 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 15M 4-64									

MARYLAND STATE DEPARTMENT OF HEALTH

Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06986

CERTIFICATE OF DEATH

06977

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>HARFORD</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAURE de GRACE</i>		c. LENGTH OF STAY IN 1b <i>672 hrs.</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>HARFORD Memorial Hosp.</i>		e. STREET ADDRESS <i>366 Congress Ave</i>		
3. NAME OF DECEASED (Type or print) <i>HORACE</i>		First	Middle	
4. DATE OF DEATH <i>May 27 1966</i>		Month	Day Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <i>8/9/1916</i>		9. AGE (In years last birthday) <i>49 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Michigan</i>
13. FATHER'S NAME <i>Richard O. Fairfield</i>		14. MOTHER'S MAIDEN NAME <i>Culie Hultz</i>		12. CITIZEN OF WHAT COUNTRY <i>A.S.A.</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT <i>Thelma F. Billings</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4344</i>		DUE TO <i>Acute cardiac dilatation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pulmonary edema</i>		DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>May 27 1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>May 27, 1966</i> to <i>May 27, 1966</i> that (I) (we) last saw the deceased alive on <i>May 27, 1966</i> , and that death occurred at <i>34 M</i> , from causes and on the date stated above.				
22a. SIGNATURE <i>Frank Wudomon</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5/27/66</i>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		
23a. BURIAL/CREMATION, REMOVAL (Specify) <i>5/31/66</i>		23b. DATE THEREOF <i>5/31/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bristol Ind.</i>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <i>Conway & Son, Hanover, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE JUN 1 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06987

CERTIFICATE OF DEATH

06978

1. PLACE OF DEATH. a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood, Maryland 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kirk Army Hospital		d. STREET ADDRESS 1340 E. Grant Ct.	
3. NAME OF DECEASED (Type or print) FINSTROM, Infant Male		First FINSTROM	Middle Infant
4. DATE OF DEATH May 29 1966	Month May	Day 29	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 25 May 1966
9. AGE (In years last birthday) yrs. 22	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS. Days 8	12. IF UNDER 24 HRS. Hours 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY - - -	
13. FATHER'S NAME FINSTROM, Carl G.		14. MOTHER'S MAIDEN NAME JENSEN, Joanne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -	17. INFORMANT Infant Records -
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kernicterus 7706 OUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Erythroblastosis fetalis OUE TO (c) Hyaline membrane disease			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Premature	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 25, 1966 , to May 29, 1966 , that (I) (we) last saw the deceased alive on May 29, 1966 , and that death occurred at 10:10 P.M. from the causes and on the date stated above.		22b. DATE SIGNED Thomas Fraher M.D.	
22a. SIGNATURE Thomas Fraher M.D.		22b. DATE SIGNED Thomas Fraher M.D.	
22c. PHYSICIAN'S NAME (Type) THOMAS FRAHER, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 1, 66	23c. NAME OF CEMETERY OR CREMATORIUM Post Cemetery
24. FUNERAL DIRECTOR Kenneth B. George		ADDRESS Tarring Funeral Home	25a. REC'D BY REGISTRAR JUN 3 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

—classmate —

—M. M. BREATH GARDNER

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06979

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE		Md		b. COUNTY		Harford	
Harford Home & Street		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Fallston		d. STREET ADDRESS		12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		D. O. T. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	May	Month	13	Doy	Year	166
4. SEX		5. COLOR OR RACE	6. MARRIED WIDOWED	7. NEVER MARRIED DIVORCED	8. DATE OF BIRTH	Nov 21 1934	9. AGE (In years last birthday)	31	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours	12. DYS. Min.
10. DO: USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		Williamsport Pa		12. CITIZEN OF WHAT COUNTRY?		U.S.	
13. FATHER'S NAME		Samuel Fromille		14. MOTHER'S MAIDEN NAME		Mildred E. Warrenberger		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO.	
16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		Fracture skull, nose, & femur, multiple ribs, left forearm		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 8194 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		DUE TO (b) DUE TO (c)		Fracture skull, nose, & femur, multiple ribs, left forearm		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, auto object type	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 5 13 19 66 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Mountain Rd		20f. (City or town) Towson Ha. Md.		(County) Baltimore Co.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Gerald C Palmer		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		Bel Air Md.		22. DATE SIGNED 5-14-66	
EXAMINER'S NAME (Type)		Gerald C Palmer		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF May 16, '66		23c. NAME OF CEMETERY OR CREMATORIAL Friendship Methodist		23d. LOCATION (City or Town) Fallston Md		(County) Harford		(State) Md.	
24. FUNERAL DIRECTOR		ADDRESS W. H. Archer, Benson Md		25a. REC'D BY REGISTRAR MAY 20 1956		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

.06989

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06980

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
Hayes		Maryland		a. STATE	b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Hawde Roads		DOA		Rising Sun 07-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
DOA Hayes Memorial Hospital		RD 1		19		
3. NAME OF DECEASED James Wade Gibson		First	Middle	Last	Month Day Year	
(Type or print)		Wade	Gibson	May 8	1966	
4. SEX M		5. COLOR OR RACE W		6. DATE OF BIRTH Sept. 12, 1946		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years if under 1 year, if over 1 year, if under 24 hrs, if over 24 hrs)		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		
Machine Operator		Paper Company		Maryland		
13. FATHER'S NAME George C. Gibson		14. MOTHER'S MAIDEN NAME Faye Hawley		12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-46-0946		17. INFORMANT Mr. Geo. Gibson, Rising Sun, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 8254		Fracture Skul				
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		DUE TO (b)	Cushing injury Chest			
		DUE TO (c)	Fracture L femur			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMAR ^Y OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 4 into Accident				
20c. TIME OF INJURY Month, Day, Year Hour 5-846 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1548		20f. (City or town) (County) (State) Perryville Cecil Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Robert C. Palmer</i>
ACTUAL SIGNATURE <i>Robert C. Palmer</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <i>5-9-66</i>
EXAMINER'S NAME (Type) <i>Robert C. Palmer</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
Address (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 11, 1966		23c. NAME OF CEMETERY OR CREMATORI Ebenezer Cemetery		23d. LOCATION (City, town or county) (State) North East, Md.
24. FUNERAL DIRECTOR <i>Lee A. Patterson, Jr.</i>		ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR AISM (5) 5M 1/65				DATE MAY 17 1966		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06990 06981

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Home de Harford</i> DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perryville</i> 07-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John Dawson Gilman</i>	First <i>John</i> Middle <i>Dawson</i> Last <i>Gilman</i>	4. DATE OF DEATH <i>May 9 1966</i>	Month <i>May</i> Day <i>9</i> Year <i>1966</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 6, 1946</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter's Assistant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Dawson S. Gilman</i>		14. MOTHER'S MAIDEN NAME <i>Frances J. Poole</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Mrs. Linda D. Gilman, Perryville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull</i> DUE TO <i>Crushing injury R. side</i> INTERVAL BETWEEN ONSET AND DEATH <i>8254</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Auto accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>11 p.m.</i> 5-8-66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 75-40	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Perryville Cecil Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>Rey April 11 1966</i>	
ACTUAL SIGNATURE <i>Gerald E. Palmer</i> EXAMINER'S NAME (Type) <i>Gerald E. Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>May 13, 1966</i> 23c. NAME OF CEMETERY OR CREMATORIAL <i>Principio Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Principio Furnace Md</i>	
24. FUNERAL DIRECTOR <i>See A. Pattersonson, Perryville, Md.</i>		ADDRESS	
25a. REC'D BY REGISTRAR <i>MAY 17 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06991

CERTIFICATE OF DEATH

06982

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, during any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Harford Maryland		Md. b. COUNTY Harford.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Harrode-Grace 26 hrs.		Bel Air 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Harford Memorial Hospital		R.F.D. Box 334	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH First Middle Last Month Day Year	
Cora Mitchell Gorrell		5 27 1966	
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED WIDOWED		8. DATE OF BIRTH	
<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Jan. 4, 1894	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
72 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Teacher		Public school	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
Md.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Alexander Mitchell		Debtia Chesney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
no		212-16-0383	
17. INFORMANT		18. Address	
Herbert M. Gorrell (Husband)			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:		20. INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Myocardial infarction, anterior Coronary thrombocclusive descending Atherosclerotic cardiovascular disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-27, 1966, to 5-27, 1966, that (I) (we) last saw the deceased alive on 5/27 1966, and that death occurred at 3 P.M., from causes and on the date stated above.		22b. DATE SIGNED 5/27/66	
22c. SIGNATURE Richard J. Colfer		22d. ADDRESS Harford Memorial Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 30, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Calvary Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		25a. RECD. BY REGISTRAR DATE JUN 1 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

527

4

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06992

06983

1. PLACE OF DEATH a. COUNTY	Harford			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Maryland			a. STATE	Md		
c. LENGTH OF STAY IN 1b	8 days			b. COUNTY	Harford		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Hartford Memorial			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Forest Hill		
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
F	Maria	Ellen	Gorwood	Sept. 24, 1891	5	3	1966
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
F	W	<input type="checkbox"/>	<input type="checkbox"/>	Sept. 24, 1891	94 yrs.	Months	Days
WIDOWED	DIVORCED					Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife	Homemaker	London, England			U.S.A.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
John Mumford	Woods			Maria Mumford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address				
NO	213-52-5841	Daughter	692-6119	Bob # 374	Bob # 374	Forest Hill, Md. 21050	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralytic ileus</u>							
423 OUE TO <u>Mesenteric thrombosis</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S. C.V.D. advanced</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abdominal aortic aneurysm</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED White at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 19	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 20, 1966</u> to <u>May 3rd, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 3rd, 1966</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.	22b. DATE SIGNED <u>5/3/66</u>						
22a. SIGNATURE <u>Edward C. Loo</u>	22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.	22d. ADDRESS Haute de Grace, Md.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	M.D. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 8, 1966	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town or county) Brewer, Penobscot Co., Maine				
24. FUNERAL DIRECTOR Joseph William Foster	ADDRESS W. Broadway & Williams Sts Bel Air, Maryland 21014	25a. REC'D BY REGISTRAR MAY 6 1966	25b. REGISTRAR'S SIGNATURE Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06993

06984

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page _____ be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH

a. COUNTY

Md HARFORD County
MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural - Abingdon

c. LENGTH OF STAY IN 1b

2 1/2 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

621 Long Bar Harbor Road

3. NAME OF
DECEASED
(Type or print)First: W. Middle: Iton
Last: Lee Grant

4. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

May 20, 1901

9. AGE (in years
last birthday)10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Dairy Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Agriculture

11. BIRTHPLACE (County & State, or foreign country)

Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William L. Grant

14. MOTHER'S MAIDEN NAME

Theresa M. Wicker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or date of service)

NO

16. SOCIAL SECURITY NO.

213-26-5142

17. INFORMANT (With) 676-1360 Address

Mrs. Ida B. Grant

621 Long Bar Harbor Road
Abingdon, Maryland 21009INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

coronary Occlus, D.N.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19 20d. INJURY OCCURRED
While at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
20f. (City or town) (County) (State)21. I certify that (I) (This hospital) attended the deceased from 1-1, 1938 to 5-6, 1966, that (I) (we) last
saw the deceased alive on 5-1, 1966, and that death occurred at 9 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Gerald C Palmer M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
5-6-6622c. PHYSICIAN'S
NAME (Type)

Gerald C Palmer, M.D.

22d. ADDRESS

Baltimore, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

May 9, 1966

23c. NAME OF CEMETERY OR CREMATORI

Mt. Zion Methodist Cemetery

23d. LOCATION (City, town or county)

Fountain Green, Harford Co., Maryland (State)

24 FUNERAL DIRECTOR'S SIGNATURE

W. Broadway & Williams Sts.
Bel Air, Maryland 21014

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MAY 9 1966 Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

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05994

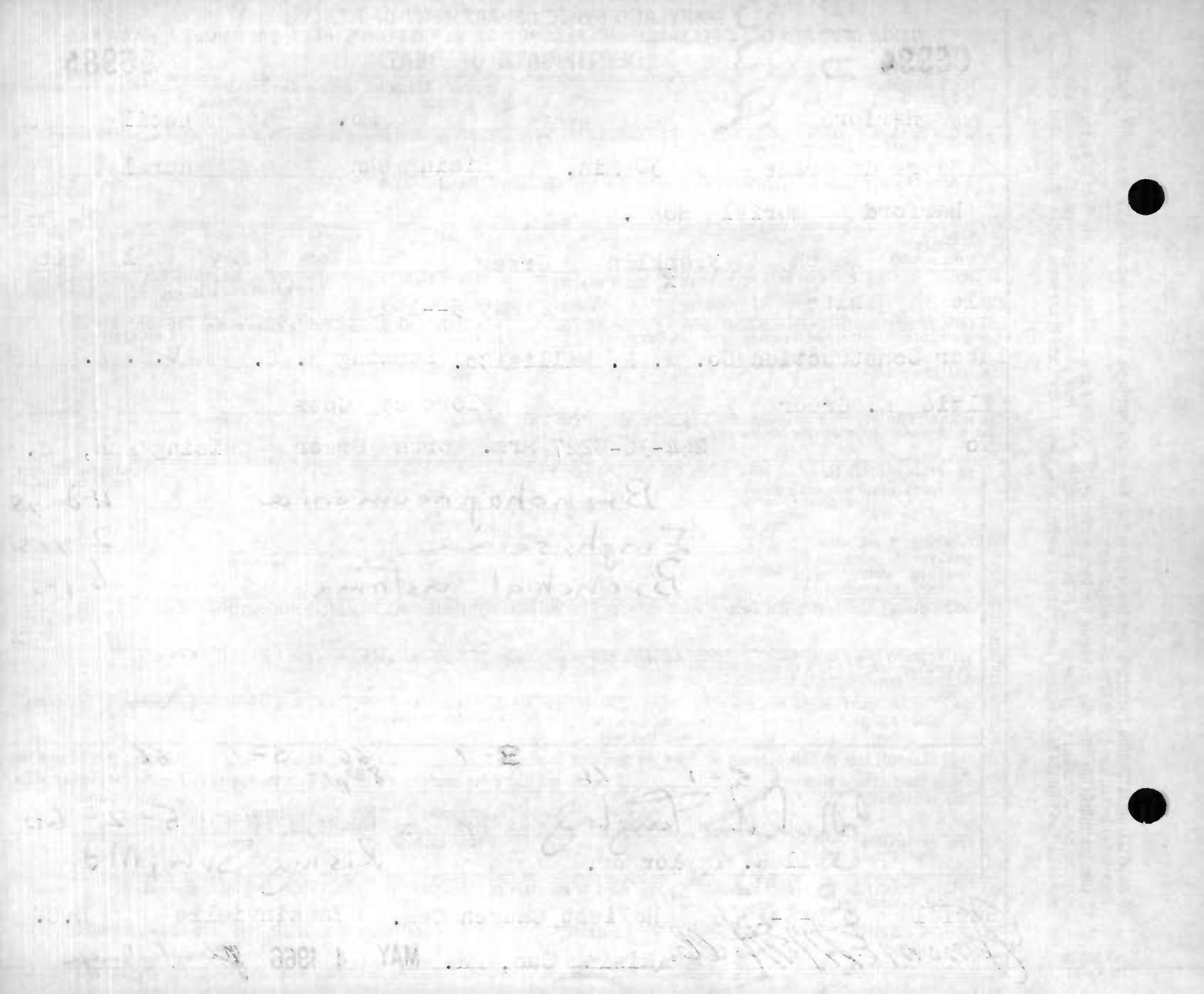
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06985

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hayre de Grace c. LENGTH OF STAY IN 1b 30 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun d. STREET ADDRESS Rural 07-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Worth Franklin Greer		First Worth Middle Franklin Last Greer	4. DATE OF DEATH Month May Day 1 Year 1966
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED May 5-1923	9. AGE (In years last birthday) 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Construction Co.		10b. KIND OF BUSINESS OR INDUSTRY R. M. Willis Co.	11. BIRTHPLACE (County & State, or foreign country) Lancing N. C.
13. FATHER'S NAME Elzie K. Greer		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 244-30-9227	17. INFORMANT Mrs. Worth Greer
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address Rising Sun, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X		INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Emphysema		2 yrs	
(c) Bronchial asthma		6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERTHLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-1 , 19 66 , to 5-1 , 19 66 , that (I) (we) last saw the deceased alive on 5-1 , 19 66 , and that death occurred at 8:30 PM, from the causes and on the date stated above.		22b. DATE SIGNED 5-2-66	
22a. SIGNATURE Neil R. Taylor Jr.		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> M.E. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Rising Sun, Md.
22c. PHYSICIAN'S NAME (Type) Neil R. Taylor Jr.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-5-1966 23c. NAME OF CEMETERY OR CREMATORIAL Holiest Church Cem. 23d. LOCATION (City, town or county) (State) Yadkinville N.C.	
24. FUNERAL DIRECTOR J. M. Muller		ADDRESS Rising Sun, Md.	25a. REC'D BY REGISTRAR MAY 4 1966 25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. **Print** and **Sign**.
The funeral director, page 3, should be filed with the State Dept. of Health prior to burial, cremation, or removal, **ond in any event, within 72 hours after death.**

06995		06986	
<p>1. PLACE OF DEATH a. COUNTY Harford MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Darlington</p> <p>c. LENGTH OF STAY IN lb 86 years</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.#2</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Darlington</p> <p>d. STREET ADDRESS R.D.#2</p> <p>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>3. NAME OF DECEASED First ETTA Middle WINIFRED Last HARKINS</p> <p>S. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>4. DATE OF DEATH May 6, 1966</p> <p>8. DATE OF BIRTH June 28, 1879 9. AGE (In years last birthday) yrs. 86 yrs.</p> <p>11. BIRTHPLACE (County & State, or foreign country) Darlington, Md.</p> <p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Edwin H. Klair</p>		<p>14. MOTHER'S MAIDEN NAME Sally B. Jones</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. -----</p>		<p>17. INFORMANT Mrs. Charles Ceska, Jr. Address Ellicott City Maryland</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 4201</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____</p> <p>(c) Chr. arterio-sclerotic cardio-vascular disease ?</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 30 Min.</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work</p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from Dec. 25, 1947, to May 6, 1966 that (I) (we) last saw the deceased alive on May 3, 1966, and that death occurred at 8 p.m., from causes and on the date stated above.</p>			
<p>22a. SIGNATURE Willard P. Hudson</p>		<p>22b. DATE SIGNED May 7, 1966</p>	
<p>22c. PHYSICIAN'S NAME (Type) Willard P. Hudson M.D.</p>		<p>22d. ADDRESS Forest Hill, Md.</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF May 9, 1966</p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL Darlington</p>		<p>23d. LOCATION (City or Town) (County) (State) Darlington, Md.</p>	
<p>24. FUNERAL DIRECTOR John H. Harkins</p>		<p>ADDRESS Delta, Penna.</p>	
<p>25a. REC'D BY REGISTRAR MAY 11 1966</p>		<p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>	

1 FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 16 Film #G377 5/2/66 pc

06996 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06987

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair		c. LENGTH OF STAY IN lb Baltimore 03-2	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 18 Dihedral Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woods-near Joppa Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle C. Hilderbrand		4. DATE OF DEATH Month 5 Doy 30 Year 1966	
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
9. AGE (In years lost birthday) 54 yrs.		10. DATE OF BIRTH Sept. 29, 1911	
11. BIRTHPLACE (State or foreign country) Frederick, Md. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob John Hilderbrand		14. MOTHER'S MAIDEN NAME Fannie Fagan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-10-2217	
17. INFORMANT Mrs. Helen V. Hilderbrand		Address 4111 White Ave Balt. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Carbon monoxide poisoning 9731 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) inhalation of exhaust fumes	
20c. TIME OF INJURY Month, Day, Year Hour xxx 12:50 p.m. 5 30 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) woods
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		20f. (City or town) (County) (State) Joppa Harford Md.	
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 5/31/66	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-3-66	23c. NAME OF CEMETERY OR CREMATORIAL unions Chapel Cemetery
24. FUNERAL DIRECTOR Robert E. Dailey Jr.		ADDRESS	25a. LOCATION (City or Town) (County) (State) Frederick Co. Md.
		25b. REC'D BY REGISTRAR DATE JUN 1 1966	25b. REGISTRAR'S SIGNATURE Charles J. J. Charles J. J.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06997

CERTIFICATE OF DEATH

06988

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		c. LENGTH OF STAY IN lb <u>33 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> 12-1	
3. NAME OF DECEASED (Type or print) <u>Edgar</u> First <u>STEVENS</u> Middle <u>S.</u> Last <u>Hoffman</u>		d. STREET ADDRESS <u>Box 150</u>	
4. DATE OF DEATH <u>MAY 26 1966</u>		Month	Day
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		9. AGE (In years lost birthday) <u>60</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>	
13. FATHER'S NAME <u>Abraham Hoffman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-01-0999</u>	
17. INFORMANT (Wife) <u>Mrs. Burnice B. Hoffman</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of the</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>gastro carcinoma</u> 4 mos		INTERVAL BETWEEN ONSET AND DEATH 2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Baltimore</u> (County) <u>Harford Co.</u> (State) <u>Md.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1966</u> to <u>May 26, 1966</u> that (I) (we) last saw the deceased alive on <u>May 26 1966</u> , and that death occurred at <u>3:20</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>B. J. Plunkett, Jr., M.D.</u>		22b. DATE SIGNED <u>5-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. J. Plunkett, Jr., M.D.</u>		22d. ADDRESS <u>Baltimore 617 W. Bel Air Avenue, Aberdeen, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 31, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) <u>Baltimore</u> (County) <u>Harford Co.</u> (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		ADDRESS <u>W. Broadway & Williams St., Bel Air, Maryland 21014</u>	
		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
		DATE <u>MAY 31 1966</u>	

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1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY	Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	Maryland		b. COUNTY	Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Havre de Grace		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Aberdeen		13-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Harford Memorial Hospital		d. STREET ADDRESS 104 Post Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Month May		Day 2	Year 1966				
3. NAME OF DECEASED (Type or print)	First Emory	Middle Lee	Last Howlett	4. DATE OF DEATH May 2 1966	Month May	Day 2	Year 1966	5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 20, 1898	9. AGE (in years last birthday) 68 yrs.	FUNDER 1 YEAR Months Days Hours Hours Min.	FUNDER 24 HRS Hours Hours Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Supervisor of Harford Pct.		10b. KIND OF BUSINESS OR INDUSTRY Retired A.P.G.	11. BIRTHPLACE (County & State, or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME George Henry Howlett	14. MOTHER'S MAIDEN NAME MARY ANN REED		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT G. RICHARD HOWLETT 105 N 18 ST, R.D. ADEREEN, MO.	Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1533 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		respiratory failure - Congestion (b) Carcinoma face (c) beginning of Carcinoma		INTERVAL BETWEEN DEATH AND DEATH 4-5 days										
DUE TO		DUE TO		DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 19	(County)	(State)									
21. I certify that (I) (this hospital) attended the deceased from April 1 28, 1966, to 2 May, 1966, that (I) (we) last saw the deceased alive on 2 May 1966, and that death occurred at 8A M, from the causes and on the date stated above.	22a. SIGNATURE Charles J. Foley Jr.		22b. DATE SIGNED 5/2/66											
22c. PHYSICIAN'S NAME (Type) CHARLES J. FOLEY JR.	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF May 4, 1966	23c. NAME OF CEMETERY OR CREMATORIUM WESLEYAN CHAPEL CEM.	23d. LOCATION (City, town or county) HARFORD CO.	(State) MD										
24. FUNERAL DIRECTOR R. Madison Mitchell, Havre de Grace Md.	ADDRESS	25a. REC'D BY REGISTRAR MAY 9 1966	25b. REGISTRAR'S SIGNATURE Charles Judge											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Harford</i>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>				c. LENGTH OF STAY IN 1b <i>2 days</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>				e. STREET ADDRESS <i>Rt. 1 Box 180</i>							
3. NAME OF DECEASED (Type or print) <i>Baby</i>				First <i>Boy</i>	Middle <i>Isennock</i>	Last <i></i>	4. DATE OF DEATH Month <i>MAY</i>	Day <i>6</i>	Year <i>1966</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>				6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 4, 1966</i>	9. AGE (In years last birthday) yrs. <i></i>	FUNDER 1 YEAR Months <i>2</i>	Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Harford Md.</i>			
13. FATHER'S NAME <i>Frederick B. Isennock</i>				14. MOTHER'S MAIDEN NAME <i>Alberta L. Lloyd</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>				17. INFORMANT <i>Frederick B. Isennock, Rt. 1, Box 180, Rocks,</i>			
Address <i>Md.</i>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Respiratory distress syndrome</i> DUE TO (c) <i>Prematurity</i> INTERVAL BETWEEN ONSET AND DEATH											
7699 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Maternal influenza</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <i></i>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>			
20f. (City or town) <i></i>				(County) <i></i>				(State) <i></i>			
21. I certify that (I) (this hospital) attended the deceased from <i>5-4 1966</i> to <i>5-6 1966</i> , that (I) (we) last saw the deceased alive on <i>5-6 1966</i> , and that death occurred at <i>10 AM</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Richard Norment, M.D.</i>											
22b. DATE SIGNED <i>5-7-66</i>											
22c. PHYSICIAN'S NAME (Type) <i>Richard Norment, M.D.</i>				22d. ADDRESS <i>602 S. Union Ave., Havre de Grace, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>May 9, 1966</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>BelAir Memorial Gardens</i>			
24. FUNERAL DIRECTOR <i>Howard K. McComas & Son, Abingdon, Md. 21009</i>				23d. LOCATION (City, town or county) <i>BelAir</i>							
ADDRESS <i></i>				25a. REC'D BY REGISTRAR <i></i>							
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				DATE <i>MAY 10 1966</i>							

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FOR STATE
HEALTH DEPT.
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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06991

1. PLACE OF DEATH a. COUNTY <i>Hanford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethel</i>		c. LENGTH OF STAY IN 1b <i>10 days.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hanford Convalescent Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanford Grace</i>	
3. NAME OF DECEASED (Type or print) <i>Emily C. James</i>		d. STREET ADDRESS <i>222 Washington St</i>	
4. DATE OF DEATH Month <i>May</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <i>4-7-95</i>		10. AGE (In years last birthday) <i>91 yrs.</i>	
11. BIRTHPLACE (State or foreign country) <i>Hanford Grace</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph A. Pennington</i>		14. MOTHER'S MAIDEN NAME <i>Bedelia Hollahan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Pennington</i>	
17. INFORMANT <i>Mr. Pennington</i>		18. ADDRESS <i>222 Washington St Hanford, Md</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture L- femur</i>		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <i>Arteriosclerotic ev Disease</i>	
23. MEDICAL CERTIFICATION PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		24. EXTERNAL CAUSE WAS DUE TO (b) DUE TO (c)	
25. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> 5 p.m. p.m. <i>4-27 1966</i>		26. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <i>Fell at home</i>	
27. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. (City or town) (County) (State) <i>Hanford Grace Hanford</i>	
29. ACTUAL SIGNATURE <i>Gerald C. Palmer</i>		30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
31. EXAMINER'S NAME (Type) <i>Gerald C. Palmer</i>		32. DATE SIGNED <i>5-7-66</i>	
33. BURIAL, CREMATION, REMOVAL (Specify) <i>5/9/66</i>		34. DATE THEREOF <i>5/9/66</i>	
35. CEMETERY OR CREMATORIAL ADDRESS <i>Green Hill</i>		36. LOCATION (City or Town) (County) (State) <i>Hanford Grace, Md</i>	
37. FUNERAL DIRECTOR <i>Pennington Pen, Hanford Grace, Md</i>		38. REC'D BY REGISTRAR DATE <i>MAY 11 1966</i>	
39. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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May 12th 1907

Introduction

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Mr. G. A. S.

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Section 1.1

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~use~~ ^{copy} carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 should be filed with the State Dept. of Health.

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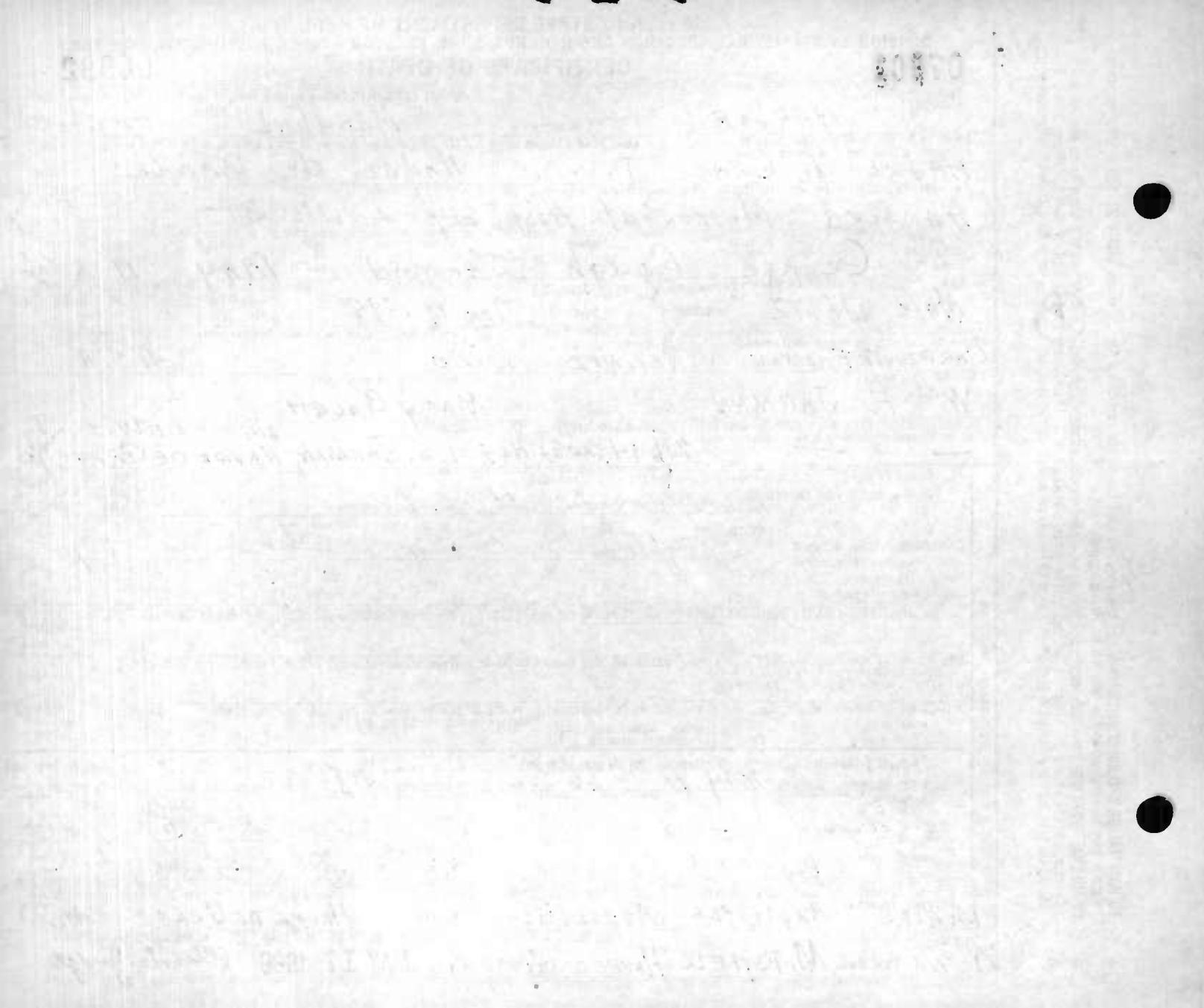
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07001

CERTIFICATE OF DEATH

06992

1. PLACE OF DEATH a. COUNTY		HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b D.C.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD Memorial Hosp.		d. STREET ADDRESS 614 Lewis St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle Gough	Last JARMAN	4. DATE OF DEATH	Month MAY Day 11 Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 19 1898	9. AGE (in years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER/REMAN		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (County & State, or foreign country) Mp.	
13. FATHER'S NAME W.M. F. JARMAN		14. MOTHER'S MAIDEN NAME MARY Gough		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-14-2080		17. INFORMANT 614 Address LEWIS ST. HAZEL S. JARMAN, HAURE DE GRACE, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		Coronary thrombosis			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	hypertension, cardio vascular disease		1 yr
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) p.m. 19 While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on May 11 1966, and that death occurred at 8:52 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Edward S. Simon		22b. DATE SIGNED 5/14/66			
22c. PHYSICIAN'S NAME (Type) Edward S. Simon		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 14, 1966	23c. NAME OF CEMETERY OR CREMATORIUM ANGEL HILL CEM	23d. LOCATION (City, town or county) (State) HAURE DE GRACE MD	
24. FUNERAL DIRECTOR R. Madison MITCHELL HAURE DE GRACE, MD		ADDRESS		25a. REC'D BY REGISTRAR MAY 17 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20M 1/65		DATE			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation, or removal, and in any event, within 72 hours after death.

07002

CERTIFICATE OF DEATH

06993

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 3 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford		d. STREET ADDRESS Bay Rd - Green Acres					
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Bay Rd - Green Acres		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Charlotte		First J.	Middle J.	Lost Jones	4. DATE OF DEATH MAY 24, 1966	Month May	Doy 24	Year 1966			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 1, 1884		9. AGE (In years, last birthday) 81	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. KIND OF BUSINESS OR INDUSTRY 		12. BIRTHPLACE (County & State, or foreign country) YORK CO., PA.		13. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME JACOB HENRY		14. MOTHER'S MAIDEN NAME HARRIET BARBEN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-12-8799A		17. INFORMANT Mrs. ELSIE CHEEK, Whiteford, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 		(b) DUE TO 		(c) DUE TO Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sensitity		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-21 , 19 66 to 5-24 , 19 66 that (I) (we) last saw the deceased alive on 5-24 19 66 , and that death occurred on 5-24 M, from causes and on the date stated above.		22b. DATE SIGNED 5/24/66									
22a. SIGNATURE George T. Stanbury		22b. DATE SIGNED 5/24/66									
22c. PHYSICIAN'S NAME (Type) George T. Stanbury		22d. ADDRESS 569 Revolution St. Havre de Grace, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 26, 1966		23c. NAME OF CEMETERY OR CREMATORIAL SLATE RIDGE		23d. LOCATION (City or Town) (County) (State) DELTA, PA.					
24. FUNERAL DIRECTOR John H. Harbins, DELTA, PA.		ADDRESS		25a. REC'D BY REGISTRAR DA		25b. REGISTRAR'S SIGNATURE Charles Judge					

4 1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 06994

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harve de Grace</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>825 Juanita Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Maggie L. Kenly</i>	First	Middle	Last
4. DATE OF DEATH Month <i>5</i> Day <i>19</i> Year <i>1966</i>	5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>July 16, 1888</i>	9. AGE (In years last birthday) <i>77 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Private Family</i>
11. BIRTHPLACE (County & State, or foreign country) <i>Aberdeen, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	13. FATHER'S NAME <i>John Kenly</i>	14. MOTHER'S MAIDEN NAME <i>Annie Williams</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs. Ellen Cooper, Abingdon, Md.</i>	Address <i>3620 B. + O. Road</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i>			
4438 Cconditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis c Left Hemiplegia</i> (c) <i>Hypertensive Cardiovascular disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Aberdeen</i> (County) <i>Harford Co.</i> (State) <i>Md.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>9/15</i> , 1960, to <i>5/19</i> , 1966, that (I) (we) last saw the deceased alive on <i>5/17</i> 1966, and that death occurred at <i>2:30 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>George T. Stansbury</i>		22b. DATE SIGNED <i>5/21/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		22d. ADDRESS <i>569 Revolution St. Harve de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-21-66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Union Methodist Cem.</i>		23d. LOCATION (City, town or county) <i>Aberdeen, Harford Co. Md.</i> (State)	
24. FUNERAL DIRECTOR <i>Otelia J. Bullock, Harve de Grace, Md.</i>		ADDRESS <i>5562 Erie St.</i> 25a. REC'D BY REGISTRAR <i>D.</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> DATE <i>MAY 23 1966</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07004

CERTIFICATE OF DEATH

06995

1. PLACE OF DEATH,
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town)

Havre de Grace

9 days

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Harford Memorial

3. NAME OF
DECEASED
(Type or print)

First.

Middle

Last

4. DATE
OF
DEATH

Month
5

Day
14

Year
1966

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

6 Oct. 1887

9. AGE (In years
last birthday)

78
yrs.

10. IF UNDER 1 YEAR

Months
Days
Hours
Min.

11a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

11b. KIND OF BUSINESS OR
INDUSTRY

Housewife

Home

11. BIRTHPLACE (County & State, or foreign country)

New York

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

Louis Lang

14. MOTHER'S MAIDEN NAME

Elizabeth Peters

15. WAS DECEASED EVER IN U.S. ARMEO FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFDRMAN

Address

Vivian Langewisch, same as 2 C & D

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

5722

OUT TO

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

Hemorhagic Ulcerative Colitis

INTERVAL BETWEEN
ONSET AND DEATH

Year

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDECIAL CERTIFICATION

20a. ACCIOENT WAS UNDERRYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDECIAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 5/5/66, 19, to 5/6/66, 19, that (I) (we) last saw the deceased alive on 5/4/66, 19, and that death occurred at 7:30 M, from the causes and on the date stated above.

22a. SIGNATURE

John G. Grigoleit

22b. DATE SIGNED

5/5/66

22c. PHYSICIAN'S
NAME (Type)

A. G. Grigoleit

22d. ADDRESS

Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF 16 May 66
23c. NAME OF CEMETERY OR CREMATORIUM The Evergreens Cemetery

23d. LOCATION (City, town or county) (State)
Brooklyn, New York

24. FUNERAL DIRECTOR

John H. Tanning

Tanning Funeral Home
Aberdeen, Maryland

25a. REC'D BY REGISTRAR
MAY 17 1966

25b. REGISTRAR'S SIGNATURE
Charles Judge

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												06996					
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)					
HARFORD MARYLAND				HARFORD de Grace				6 days				a. STATE MARYLAND b. COUNTY HARFORD					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				HARFORD Memorial Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				Perryman 12-1					
3. NAME OF DECEASED (Type or print)				First	Middle	Last		4. DATE OF DEATH		Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. UNDER 1 YEAR		11. UNDER 24 HRS.					
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 9, 1905		60 yrs.		Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
Salesman				Car				Harford Co. Md.				USA					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME													
Isaac Sailor Lee				Sarah Kehoe													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
No				215-09-1560				Laura McComas Lee, Perryman, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure Following Cardiac Arrest</i>																	
443X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe Anemia (P.A.?)</i>																	
DUE TO (c) <i>Hypertensive Cardiovascular disease</i>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)																	
<i>Hepatic Insufficiency (Cirrhosis)</i>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/18, 1966, to 5/23, 1966, that (I) (we) last saw the deceased alive on 5-23 1966, and that death occurred at 2:30 AM, from the causes and on the date stated above.																	
22a. SIGNATURE <i>George T. Stansbury</i>																	
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5/23/66																	
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>																	
22d. ADDRESS <i>569 Revolution St. Harford de Grace, Md.</i>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>May 26, 1966</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>Spesutia Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Perryman, Harford Co., Md.</i>					
24. FUNERAL DIRECTOR ADDRESS Howard K. McComas & Son, Abingdon, Md.																	
25a. REC'D BY REGISTRAR <i>MAY 25 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																	

0001 22 MAY

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07006

CERTIFICATE OF DEATH

06997

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<p>a. COUNTY <u>Harford</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u></p> <p>c. LENGTH OF STAY IN lb <u>28 hrs.</u></p>		<p>a. STATE <u>Md</u> b. COUNTY <u>Harford</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u></p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u></p>		<p>d. STREET ADDRESS <u>Box 65</u></p>	
<p>66 3. NAME OF DECEASED (Type or print) <u>Stephen Christopher Baby Boy Martin</u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>S. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 23, 1966</u></p>	
<p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>9. AGE (In years last birthday) yrs. <u>21</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u></p>	
<p>11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>John Francis Martin</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Charlotte Ann Church</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>None</u></p>	
<p>17. INFORMANT (Father) <u>Mr. John F. Martin</u> Address <u>General Delivery - Box #65 Churchville, Maryland 21028</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>7547</u> DUE TO <u>Under respiratory distressing</u> Candidias, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Transpiration of great vessels</u> (c)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p><u>Pneumonitis (Aspiration)</u></p>		<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) <u>Bel Air</u> (County) <u>Harford Co.</u> (State) <u>Maryland</u></p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>5-24</u>, 19<u>66</u>, to <u>5-24</u>, 19<u>66</u> that (I) (we) last saw the deceased alive on <u>5-24</u> 19<u>66</u>, and that death occurred at <u>10:58</u> AM, from causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>Alonso Gomez</u></p>		<p>22b. DATE SIGNED <u>5/25/66</u></p>	
<p>22c. PHYSICIAN'S NAME (Type) <u>Alonso - Gomez</u></p>		<p>22d. ADDRESS <u>419 S. Union Ave. Havre de Grace, Md.</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE THEREOF <u>May 26, 1966</u></p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL <u>Bel Air Memorial Gardens</u></p>		<p>23d. LOCATION (City or Town) <u>Bel Air</u> (County) <u>Harford Co.</u> (State) <u>Maryland</u></p>	
<p>24. FUNERAL DIRECTOR <u>Joseph William Foster</u></p>		<p>25a. ADDRESS <u>W. Broadway & Williams St.</u></p>	
		<p>25a. REC'D BY REGISTRAR <u>MAY 31 1966</u></p>	
		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Duley</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07007

1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Aberdeen (Rural)

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Route #3, Box 145

3. NAME OF
DECEASED
(Type or print)First
CHARLESMiddle
N.Last
MCCOMMONS4. DATE
OF
DEATH

May

11

19 66

5. SEX

Male

6. COLOR OR RACE

Cau.

7. MARRIED NEVER MARRIED WIDOWED

8. DATE OF BIRTH

9. AGE (in years
last birthday)

30 April 1875

10. UNDER 1 YEAR

91

11. UNDER 24 HRS.

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Drawbridge Tender

(Ret) Harford County, Md.

Penna. R.R.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph T. McCommons

14. MOTHER'S MAIDEN NAME

Caroline Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Address

Rose McCommons, Aberdeen, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

450/

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

DUE TO

(c)

Generalized Circulatory Failure

Generalized Atherosclerosis

INTERVAL BETWEEN
ONSET AND DEATH
3 days

2 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Generalized of Left Foot

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not Whileat work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

21. I certify that (I) (we) last

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07008		Items 4, 21 Film G377		5/25/66		mh		06999			
1. PLACE OF DEATH		a. COUNTY		Mayland		b. STATE		Maryland		c. COUNTY	
1. BURIED		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Length of Stay in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Maryland		b. CITY OR TOWN	
2. BURIED		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		Burford		e. COUNT	
3. NAME OF DECEASED (Type or print)		First		Middle		f. DATE OF DEATH		May		f. DAY	
3. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		16, 1966		g. YEAR	
L		White		WIDOWED		Sept. 11-1886		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		99		Months		IF UNDER 24 HRS.	
House Wife		—		House		yrs.		Deys		Hours	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. INFORMANT		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
William Williams		Anna Johnson		Annabelle Mc Commons		569 Congress St.		Address		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
11		11		11		11		11		11	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)									
443X		INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO									
{		(b) Mild Hypertension									
DUE TO		Cerebral Vascular									
(c) Disease											
20e. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m.				While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
p.m.		19									
21. I certify that (I) (this hospital) attended the deceased from		4-2-60		19		to		5-17		1966	
saw the deceased alive on		3-17		1966		and that death occurred at		2		M. from the causes and on the date stated above.	
22e. SIGNATURE		M.D.		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)											
23e. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)			
5/19/66		5/19/66		Glenelg Hill		Burford					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25e. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Burford		Burford		MAY 20 1966		Charles Judge					
VR A15 (4)		20M S-63		DATE							

STATE DEPARTMENT OF HE.

295

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #11, 12, 13, 14 & 23a, b, c, & d. Film #G376-5/12/66 pg. 1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07000

FOR STATE
HEALTH DEPT.

If any delay is
s 1, 2, and 3 to
arm PM3. Page
99

LEGAL EXAMINER: This certificate should be executed within 24 hours of death. Execute the certificate, writing the word "pending" in pencil in Item 1b. One page of the certificate, Page 4 should be forwarded to the Chief Medical Examiner's Office along with the signed original of the certificate. **CTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State designated agent, prior to burial, cremation, or removal, and in any event within 72 hours.

CO DEPUTY MED
necessary, please
the funeral direc
s may be retain
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Health or its des

VR A15ME (3
6M 1/66

1. PLACE OF DEATH a. COUNTY Harford			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairfield Grange			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Harford Memorial Hospital			d. STREET ADDRESS Port Deposit		
3. NAME OF DECEASED (Type or print) Clyde McMullen			4. DATE OF DEATH May 5 1966	Month	Day Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 0 Dots 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Rising Sun, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph McMullen			14. MOTHER'S MAIDEN NAME Mary Alexander		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 9100			16. SOCIAL SECURITY NO.		
17. INFORMANT			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury R. chest DUE TO (b) Fractional R clavicle DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jack slipped & car fell on him			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5 p.m. 5-5-66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Port Deposit		(County) Cecil		(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gerald C Palmer					
EXAMINER'S NAME (Type) Gerald C Palmer					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/66		23c. NAME OF CEMETERY OR CREMATORIAL Brookview	
24. FUNERAL DIRECTOR Ralph M Peck		ADDRESS Rising Sun, Md.		23d. LOCATION (City or Town) Rising Sun, Md.	
25. REC'D BY REGISTRAR MAY 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		(County) Baltimore	
MEDICAL CERTIFICATION					

2000 ft

500 ft

2000 ft

1000 ft

1000 ft

NP

2000 ft

1000 ft

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

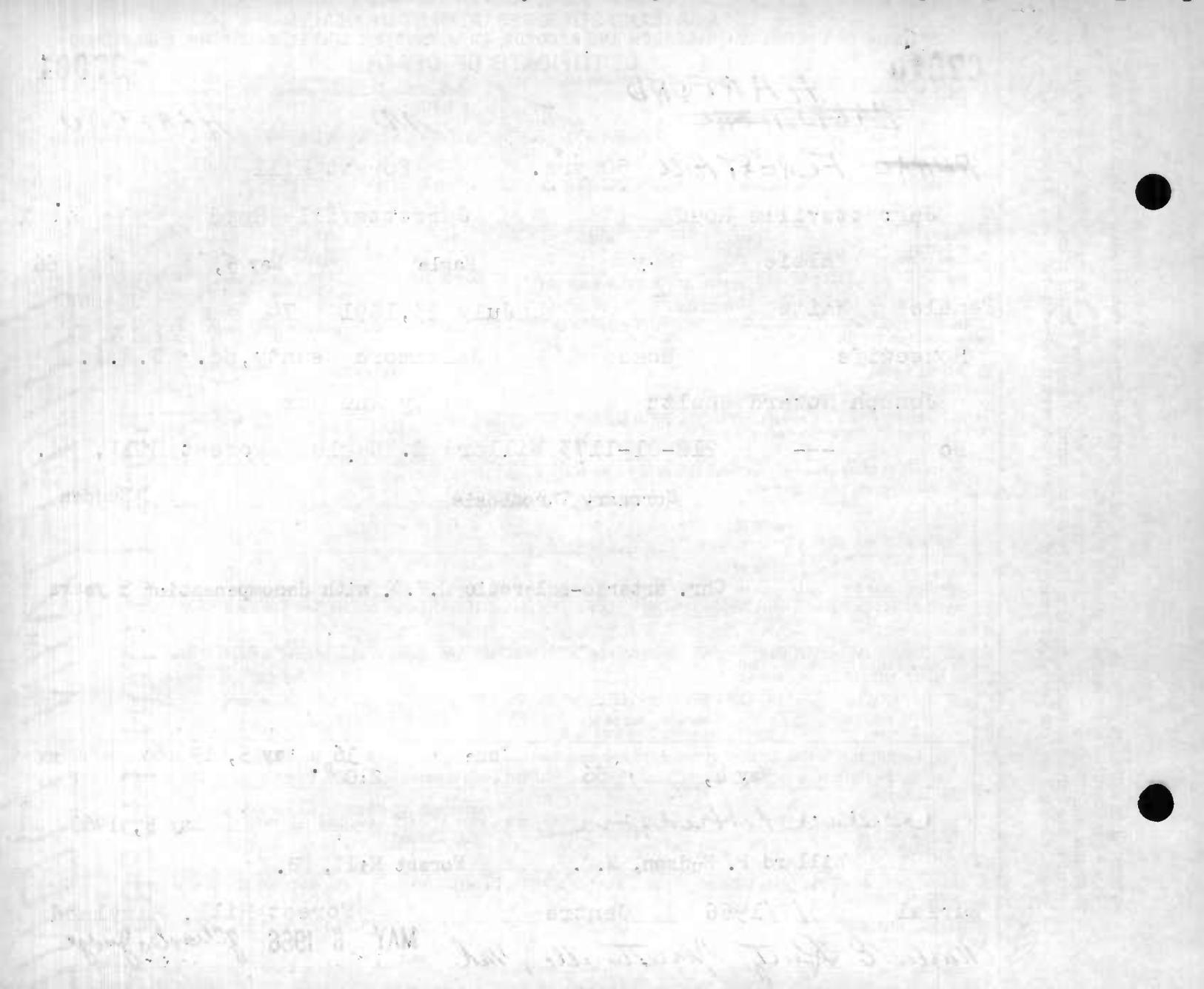
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C7010

07001

1. PLACE OF DEATH a. COUNTY	HARFORD BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	MD.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Centre		b. COUNTY	HARFORD		
c. LENGTH OF STAY IN 1b	50 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Forest Hill		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Jarrettsville Road		d. STREET ADDRESS	Jarrettsville Road		
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH	Month	Day Year	
	Elsie	May	Nagle	May 5,	19 66	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. FUNDER 1 YEAR Months Days Hours Min.	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 23, 1891	74 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
Housewife	Home	Baltimore County, Md.	U.S.A.			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME					
Joseph Howard Shultz		Sally Ann Cox				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No	16. SOCIAL SECURITY NO. <input type="checkbox"/> ---	17. INFDRMT	Address			
218-01-1173 Willard S. Nagle Forest Hill, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis						
4201 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____						
DUE TO (c) Chr. arterio-sclerotic C.V.D. with decompensation 3 years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Forest Hill, Md.	(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19, 1966, to May 5, 1966, that (I) (we) last saw the deceased alive on May 4, 1966, and that death occurred at 2:00M, from the causes and on the date stated above.						
22a. SIGNATURE Willard P. Hudson						
22b. DATE SIGNED May 5, 1966						
22c. PHYSICIAN'S NAME (Type)	Willard P. Hudson, M.D.		ATTENDING M.D. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS Forest Hill, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City, town or county)	(State)		
Burial	5/7/1966	Centre	Forest Hill, Maryland			
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR MAY 6 1966	25b. REGISTRAR'S SIGNATURE Charles E. Kuntz Jarrettsville, Md.		
Charles E. Kuntz Jarrettsville, Md.			DATE			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M 07011		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)	
1. PLACE OF DEATH a. COUNTY <i>Harford</i> <i>Maryland</i>		a. STATE <i>Maryland</i> <i>Towson</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hardey de Grace</i> <i>11 yrs</i>		b. COUNTY <i>Towson</i>	
c. LENGTH OF STAY IN 1b <i>11 yrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hardey de Grace</i> <i>12-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Beverly Nursing Home</i>		d. STREET ADDRESS <i>422 Ontario St.</i>	
3. NAME OF DECEASED (Type or print) <i>Jennie Catherine</i>		4. DATE OF DEATH Month Day Year <i>5/13/66</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/12/1883</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (in years at birth) <i>83 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Brooklyn N. Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nils Persson</i>		14. MOTHER'S MASTEN NAME <i>Mary Nelson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>Unknown Ruth H. Lynch 727 Ontario St., Hardey de Grace Md.</i>	
17. INFORMANT <i>Edward J. Simon</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>generalized Cerebral collapase</i> DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Cardiac failure</i> DUE TO (c) <i>arterio sclerotic hypertension, Cardiac decomp.</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>one day</i> <i>3 months</i> <i>6 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 30, 1966</i> to <i>May 13, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 13, 1966</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>5/14/66</i>	
22a. SIGNATURE <i>Edward J. Simon</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Edward J. Simon</i>		22d. ADDRESS <i>Hardey de Grace, Md.</i>	
23a. BURIAL/CREMATION/REMOVAL (Specify) <i>5/17/66</i>		23b. DATE THEREOF <i>5/17/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt. Zion</i>		23d. LOCATION (City, town or county) (State) <i>Hardey de Grace, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Parsons Ray Hardey de Grace, Md.</i>		25a. REC'D. BY REGISTRAR DATE <i>MAY 20 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

50013

51059

600 U.S. YAN

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Removal, and in any event, within 72 hours after death.

C7012

1. PLACE OF DEATH
a. COUNTYHarford
MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Harve-de-Grace 18 days

c. LENGTH OF STAY IN 1b

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Md

b. COUNTY

Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Harve-de-Grace

d. STREET ADDRESS

R.D#2

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Female

White

WIDOWED DIVORCED

Sept. 20, 1874

91

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

William Parker

14. MOTHER'S MAIDEN NAME

Emma Purdy

Address

Mrs. A. F. Wakefield (cousin)

INTERVAL BETWEEN
ONSET AND DEATH

24 hrs

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

331X

Cerebrovascular Accident

DUE TO

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

old age + arteriosclerosis

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from JUNE 12, 1966, to MAY 8, 1966, that (I) (we) last
saw the deceased alive on MAY 3, 1966, and that death occurred at 4:30 M, from the causes and on the date stated above.

22a. SIGNATURE

Dudley Phillips M.D.

22b. DATE SIGNED

M.D. ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

5/9/66

22c. PHYSICIAN'S
NAME (Type)

Dudley Phillips M.D.

22d. ADDRESS

DARLINGTON 2nd 21034

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

(State)

BURIAL

May 11, 1966

ROCK RON CEM.

HARFORD Co.

Md.

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

R. Madison Mitchell, Harve-de-Grace, Md.

MAY 12 1966

Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT M

07013

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07004

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. STATE Maryland		b. COUNTY Cecil	
3. NAME OF DECEASED (Type or print) Horace		First H.	Middle Petrea
4. DATE OF DEATH May 31, 1910		Month May	Day 3
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 31, 1910		9. AGE (In years lost birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Explosive Operator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mose L. Petrea		14. MOTHER'S MAIDEN NAME Florence Furr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 238-20-5833	
17. INFORMANT Carenner S. Petrea		Address R.D. 1 North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9103 DUE TO Hemorrhage due to severance left carotid and subclavian arteries.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMAR Y <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shell fragment struck him	
20c. TIME OF INJURY Month, Day, Year 3 p.m. Mat 3 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) APG		20f. (City or town) (County) (State) APG Ha. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 5-4-66	
ACTUAL SIGNATURE <i>Gerald C. Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.	
EXAMINER'S NAME (Type) Gerald C. Palmer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/7/66	
23c. NAME OF CEMETERY OR CREMATORIAL Cypress Creek Baptist		23d. LOCATION (City or Town) (County) (State) Garland, North Carolina	
24. FUNERAL DIRECTOR Grant Funeral Home		25a. ADDRESS Box 22 North East, Md.	
		25a. REC'D BY REGISTRAR MAY 6 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

the direction that continues on subsequent lines
with the same heading and claim

**MARYLAND STATE DEPARTMENT OF HEALTH
RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

07014

02005

are executed within 24 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)	
Harford		a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Harford	
Harde de Grace		c. LENGTH OF STAY IN 1b 55 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Harford Memorial		Edge wood	
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS 2145 Battle St.	
First Baby		Last Pugh	
Middle Girl		4. DATE OF DEATH 5	
5. SEX F		5. COLOR OR RACE C	
6. MARRIED WIDOWED		7. NEVER MARRIED DIVORCED	
8. DATE OF BIRTH 5-9-66		9. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Md-USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Edgar Layton		14. MOTHER'S MAIDEN NAME Diane Pugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Lucy Pugh, 2145 Battle St., Edgewood, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying causa last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 9, 1966, to MAY 9, 1966, that (I) (we) last saw the deceased alive on MAY 9, 1966, and that death occurred at 593 M, from the causes and on the date stated above		22b. DATE SIGNED May 9, 1966	
22a. SIGNATURE Mezei		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Lajos I. Mezei, M.D.		22d. ADDRESS Harde de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 11, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL John Wesley Cemetery		23d. LOCATION (City, town or county) Abingdon, Harford Md.	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		25a. REC'D BY REGISTRAR DATE May 13, 1966	
25b. REGISTRAR'S SIGNATURE McComas			

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. It should be filed with the State Dept. of Health prior to burial, cremation, or removal.

07015

CERTIFICATE OF DEATH

07006

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb 3 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
f. STREET ADDRESS Box 73		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNIE APPLEGATE		4. DATE OF DEATH Month May Month 1966	Doy Year 25 1966
5. SEX Female		6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		9. DATE OF BIRTH July 20, 1885	
10. KIND OF BUSINESS OR INDUSTRY domestic		11. AGE (In years lost birthday) yrs. 80	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Pete Lawrence	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-30-4390		17. INFORMANT Address Mrs. Lee Suda, Box 73, Joppa, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ lost. DUE TO (c) Hypertensive Arteriosclerotic Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 25, 1966 to May 25, 1966 that (I) (we) last saw the deceased alive on May 25, 1966 , and that death occurred at 6 A.M. from causes and on the date stated above.			
22a. SIGNATURE George T. Stansbury		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/25/66
22c. PHYSICIAN'S NAME (Type) George T. Stansbury		22d. ADDRESS 569 Revolution St. Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 28, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cokesbury Memorial Cemetery
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		25a. REC'D BY REGISTRAR MAY 31 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07016

CERTIFICATE OF DEATH

07007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 101 N. Philadelphia Blvd.		d. STREET ADDRESS 101 N. Philadelphia Blvd.	
3. NAME OF DECEASED (Type or print) WILMER V. RILEY		4. DATE OF DEATH Month May 4 1966	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11 Aug. 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Operator		10b. KIND OF BUSINESS OR INDUSTRY Laundry	11. BIRTHPLACE (County & State, or foreign country) Newark, Delaware
13. FATHER'S NAME Thomas P. Riley		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-6544	17. INFORMANT Address Dorothy G. Riley, Aberdeen, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE		INTERVAL BETWEEN ONSET AND DEATH 1977X	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. GENERALIZED CARCINOMATOSIS		DUE TO (b) CARCINOMA OF PROSTATE	
DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Port Deposit, Md.
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 5-3-1966 , and that death occurred at 7:30 AM , from the causes and on the date stated above.		22b. DATE SIGNED 5-4-66	
22a. SIGNATURE John G. Morani		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> JOHN G. MORANI	
22d. PHYSICIAN'S NAME (Type) JOHN G. MORANI		22e. ADDRESS 6404 N. CHARLES ST. BALTIMORE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6 May 66	23c. NAME OF CEMETERY OR CREMATORIAL Hopewell Cemetery
24. FUNERAL DIRECTOR Terrington Funeral Home		25a. ADDRESS Aberdeen, Md.	25b. REC'D BY REGISTRAR DA
		25c. REGISTRAR'S SIGNATURE Charles Judge	MAY 9 1966

CORPORATE

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07017

CERTIFICATE OF DEATH

07008

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		c. LENGTH OF STAY IN lb 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chestnut Street				d. STREET ADDRESS Chestnut St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arthur		First Arthur Middle Last Robinson		4. DATE OF DEATH May 28 1966		Month May Doy 28 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1893		9. AGE (In years last birthday) 73 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Farm Supplies		11. BIRTHPLACE (County & State, or foreign country) Mill Green, Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph M. Robinson				14. MOTHER'S MAIDEN NAME Marcellena Scarborough			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-34-3060		17. INFORMANT Mrs. Ethel S. Robinson, Cardiff, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Cerebral Thrombosis INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ ONSET AND DEATH immediate							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Delta (County) York (State) Pa.	
21. I certify that (I) (this hospital) attended the deceased from May 28 1966 , to May 28 1966 , that (I) (we) last saw the deceased alive on May 28 1966 , and that death occurred at 4 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Josiah A. Hunt				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED May 30, 1966			
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt M.D.				22d. ADDRESS Delta, Penna.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 31, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Slateville Cemetery		23d. LOCATION (City or Town) (County) (State) Delta York Pa.	
24. FUNERAL DIRECTOR John H. Hardine				ADDRESS Delta, Pa.			
				25a. REC'D BY REGISTRAR JUN 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

80076

1950-30-11-10-21

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07018

CERTIFICATE OF DEATH

07009

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE	
Hanford. MARYLAND		Md. Hartford.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Havre-de-Grace		2 hrs 30 min	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Hartford Memorial Hospital		Bayou Villa Apts.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marguerite Boulden Rowland		First	Middle
		Last	4. DATE OF DEATH
			Month Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		White	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 69 yrs.
Catereria work		Maryland House	11. BIRTHPLACE (County & State, or foreign country) Md.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Harry R. Boulden		Ida Fleming	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		218-32-8229	Wallace M. Rowland, Havre de Grace
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN DEATH AND MEDICAL EXAMINATION	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute myocardial infarction	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	24 hours
		DUE TO (c)	1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-19, 1966, to 3-19, 1966, that (I) (we) last saw the deceased alive on 5-19, 1966, and that death occurred at <input type="checkbox"/> M, from the causes and on the date stated above.		22b. DATE SIGNED 5/19/66	
22a. SIGNATURE John D. Yun		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS HARVE de GRACE 070
22c. PHYSICIAN'S NAME (Type)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 27, 1966, West Nottingham Co, Colora, Md.		23c. NAME OF CEMETERY OR CREMATORIUM West Nottingham Co, Colora, Md.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR See A. Patterson, Peugville, Md.		ADDRESS	25a. REC'D BY REGISTRAR MAY 27 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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07019

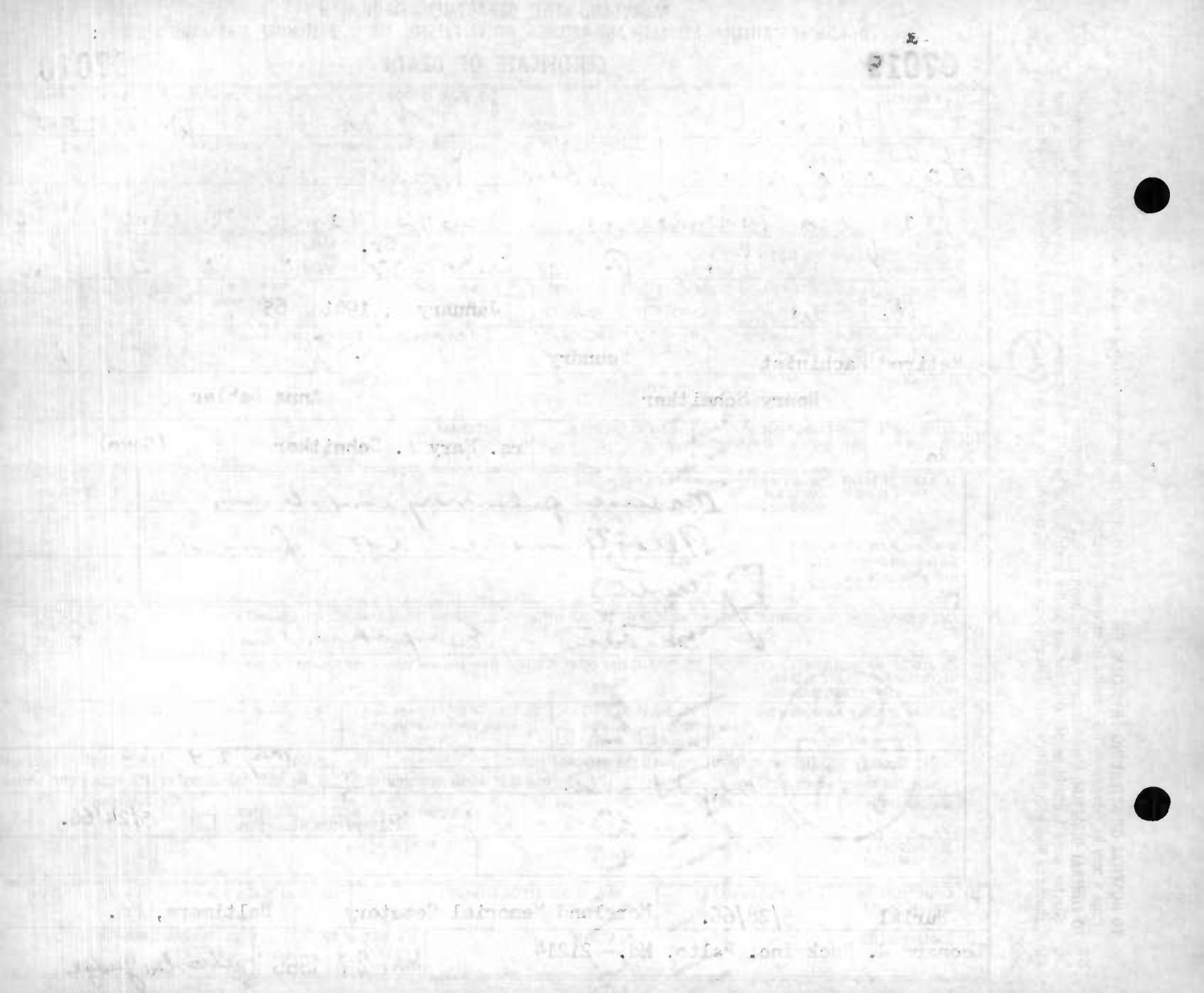
CERTIFICATE OF DEATH

07010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hawley Grace</i>		c. LENGTH OF STAY IN lb <i>2 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>George</i>	Sr. <i>Schnitker</i>
4. DATE OF DEATH	Month <i>5</i>	Day <i>24</i>	Year <i>1966</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 4, 1901</i>
9. AGE (In years at birthday) <i>85</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Machinist</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Foundry</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Henry Schnitker</i>	14. MOTHER'S MAIDEN NAME <i>Anna Dehler</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Mary A. Schnitker</i>	Address <i>(Same)</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive pulmonary embolism</i> 466 X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <i>Phlebitis - left - femoral</i> DUE TO (c) <i>Acute</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>✓ Gastritis - Esophagitis</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>May 20</i> , 1966, to <i>May 27</i> , 1966, that (I) (we) last saw the deceased alive on <i>May 24</i> , 1966, and that death occurred at <i>8 p.m.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Mrs. A. Dehler</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/28/66.</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Moreland Memorial Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md.</i>	ADDRESS <i>21214</i>	25a. REC'D BY REGISTRAR <i>MAY 27 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1 M
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07020

CERTIFICATE OF DEATH

07011

1. PLACE OF DEATH e. COUNTY <i>HARFORD</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>HARFORD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAVRE DE GRACE</i>		c. LENGTH OF STAY IN 1b <i>16 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>HARFORD MEMORIAL HOSPITAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JONATHAN DAVID SEXTON</i>		First <i>J</i>	Middle <i>DAVID</i>
4. DATE OF DEATH <i>MAY 29 1966</i>	Month <i>MAY</i>	Day <i>29</i>	Year <i>1966</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-28-66</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Japan</i>
13. FATHER'S NAME <i>Thomas W. Sexton</i>	14. MOTHER'S MAIDEN NAME <i>Lucille Parks</i>	Address <i>Thomas W. Sexton, 1827 Mountain Rd., Joppa</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Thomas W. Sexton</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>776X</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>MAY 28, 1966</i> , to <i>MAY 29, 1966</i> , that (I) (we) last saw the deceased alive on <i>MAY 29 1966</i> , and that death occurred at <i>8 A</i> M, from the causes and on the date stated above.	22a. SIGNATURE <i>F. J. Hatem</i>	22b. DATE SIGNED <i>5/29/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>F. J. Hatem, M.D.</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. ADDRESS <i>602 S. Union Ave., Havre de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>May 31, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>BelAir Memorial Gardens</i>	23d. LOCATION (City, town or county) (State) <i>BelAir</i> <i>Harford</i> <i>Md.</i>
24. FUNERAL DIRECTOR <i>Howard K. McComas & Son, Abingdon, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>JUN 1 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
<i>Harford</i> MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>HAURE de GRACE</i>		2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
<i>Harford Memorial Hosp.</i>		STAR RT.	
66		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Bessie</i>		<i>May</i>	<i>Sherman</i>
4. DATE OF DEATH		Month	Day
<i>May 21</i>		<i>1966</i>	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		White	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Housewife</i>		Home	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Churchville, Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Andrew P. Bodt</i>		<i>Cora L. Greenland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		<i>Walter</i>	
		<i>Walter H. Sherman Jr. Havre de Grace</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Generalized arteriosclerosis</i>	
4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <i>Cardiovascular disease & uremia</i>	
		DUE TO (c) <i>Congestive heart failure</i>	
		<i>Anemia</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <i>5/19</i> , 1966, to <i>5/21</i> , 1966, that (I) (we) last saw the deceased alive on <i>5/21</i> , 1966, and that death occurred at <i>69</i> M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>A. Grigoleit</i>		22b. DATE SIGNED <i>5-21-66</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
<i>Alfred W. Grigoleit, M.D.</i>		<i>608 S. Union Ave. Aberdeen, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS
Burial		<i>23 May 66</i>	<i>Smith Chapel Cemetery</i>
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
<i>John D. Tarring</i>		25b. REGISTRAR'S SIGNATURE	
		<i>Charles Judge</i>	

FRENCH 105 • 111

and others of the species. *Medicinal*

1880-1881

1. *Leucosia* *leucosia* (L.) *leucosia* (L.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07023

CERTIFICATE OF DEATH

07014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
<i>Harford</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Havre de Grace</i>		<i>9 hrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Harford Memorial Hospital</i>		07-2	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year	
<i>Infant Girl</i>		<i>Singleton</i> May 23 1966	
5. SEX		6. COLOR OR RACE	
<i>Female</i>		<i>CAU</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
<i>WIDOWED <input type="checkbox"/></i>		<i>May 23, 1966</i>	
9. AGE (in years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	
<i>11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</i>		<i>10b. KIND OF BUSINESS OR INDUSTRY</i>	
<i>No</i>		<i>11. BIRTHPLACE (County & State, or foreign country)</i>	
<i>Archie E. Singleton</i>		<i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
<i>USA</i>		<i>Vickey Stobbs</i>	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
<i>Hospital Records</i>		<i>16. SOCIAL SECURITY NO.</i>	
<i>No</i>		<i>17. INFORMANT</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
<i>776X</i>		<i>Prematurity 6 month</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 23</i> , 19 <i>66</i> , to <i>May 23</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>May 23</i> 19 <i>66</i> , and that death occurred at <i>523-66</i> M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		<i>5-23-66</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
<i>GUNTHER D. HIRSCH</i>		<i>Havre de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<i>Cremation</i>		<i>5/24/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)	
<i>Crescendo Cemetery</i>		<i>Havre de Grace, Md.</i>	
24. FUNERAL DIRECTOR		ADDRESS	
<i>A. A. O. O. Funeral Home, Perryville, Md.</i>		<i>MAY 27 1966</i>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>Charles Judge</i>			

22. 22 p.m. 22. 22 p.m. 22. 22 p.m.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

182
12026 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07015

1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Harve-de-Grace

c. LENGTH OF STAY IN 1b

11 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Pearl Regena Skipworth

4. DATE
OF
DEATH

Month Day Year

5

7

19 66

5. SEX

6. COLOR DR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Nurse

10b. KIND OF BUSINESS OR
INDUSTRY

Nursing

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

7/19/1909

9. AGE (In years
last birthday)

56 yrs

Months

Days

Hours

Min.

11. BIRTHPLACE (County & State, or foreign country)

McPherson, Kansas U.S.A.

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

Robert Burwles

14. MOTHER'S MAIDEN NAME

Beda Rehn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

Unk.

17. INFORMANT

Arthur Vining 7 Union Ave, Atchison, Kansas Mo

INTERVAL BETWEEN
ONSET AND DEATH
36 hrs

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

170X

DUE TO

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

DUE TO

Breast Carcinoma - Bilateral

Respiratory failure

Carcinoma - breast

Breast Carcinoma - Bilateral

2 yrs

15 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-27, 1966, to 5-7, 1966, that (I) (we) last
saw the deceased alive on 5-7, 1966, and that death occurred at 12 M, from the causes and on the date stated above.

22a. SIGNATURE

Charles J. Foley, Jr. M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22c. PHYSICIAN'S
NAME (Type)

CHARLES J. FOLEY, JR. HARVE DE GRACE, MD. 22d. ADDRESS

23a. BURIAL/CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)
(State)

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR
DATE

25b. REGISTRAR'S SIGNATURE

Charles Judge

2001 11 YAMA

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07025

CERTIFICATE OF DEATH

07016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 332 South Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Jennie	Middle May	Last Smith
4. DATE OF DEATH Month May Day 16 Year 1966	5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH May 3, 1910	9. AGE (In years last birthday) 56 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Demonstration Agent	10b. KIND OF BUSINESS OR INDUSTRY State Govt.
11. BIRTHPLACE (County & State, or foreign country) Maine	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Guy I. Swett	
14. MOTHER'S MAIDEN NAME Jennie May Record	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 006-10-4398	17. INFORMANT (Attorney) 838-7575 Office & Bond St. Mr. Charles H. Reed, Jr. Bel Air, Md. 21014
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1561 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		<i>Sub hepatic abscess with secondary complications from sarcoma of liver</i>	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore (County) Maryland (State) Md.		21. I certify that (I) (this hospital) attended the deceased from May 13, 1966 , to May 16, 1966 , that (we) last saw the deceased alive on May 15, 1966 , and that death occurred at 7A.M. from the causes and on the date stated above.	
22a. SIGNATURE <i>Cesar S. Vasquez M.D.</i>		22b. DATE SIGNED May 15, 1966	
22c. PHYSICIAN'S NAME (Type) Cesar S. Vasquez, M.D.		22d. ADDRESS Tollgate Road, Bel Air, Maryland 21014	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 19, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Lakeview Cemetery
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>		23d. LOCATION (City, town or county) (State) Burlington, Vermont	
25a. ADDRESS W. Broadway & Williams Bel Air, Maryland 21014		25b. REC'D BY REGISTRAR MAY 18 1966	25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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Geometric droplets

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ANSWER

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January 1962 1007

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Mem. South. Am. no. 2000.

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47

Notes on Figure

ANSWER: $\frac{1}{2} \pi r^2 h = \frac{1}{2} \pi (10)^2 (10) = 500\pi$ cubic centimeters.

Strongest root: 1.1m

—*mod. wavyas. 800 ft. 1900 ft. Lat. 45°*

ANSWER TO VARIOUS

4000 INFLUENCE OF

POLY(1,4-PHENYLENE TEREPHTHALAMIDE)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07026

Items 8, 9 Film G377 5/25/66 mh

07017

1. PLACE OF DEATH

e. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Faire de Grace

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Brennan's home

3. NAME OF DECEASED
(Type or print)

First Lillian

Middle

Last Somerville

4. DATE OF DEATH

May 13

1966

Month

Day

Year

5. SEX

6. COLOR OR RACE

Female White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Dec. 17, 1897

9. AGE (In years last birthday)

68 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Hd Co.

12. CITIZEN OF WHAT COUNTRY

U.S.

13. FATHER'S NAME

W. Elijah Somerville

14. MOTHER'S MAIDEN NAME

Elizabeth Pitcock, Bel Air

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Jean McLane

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1991

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

multiple malignancy —
Sarcoma of left legINTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/13/65, 19, to 3/13, 1966, that (I) (we) last saw the deceased alive on 3/12-66, 19, and that death occurred at M, from the causes and on the date stated above.

22e. SIGNATURE

A. H. LEWIS MD

M.D.

22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

MAY 20 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

68030

2000 U.S. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07027

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 3, 9, Film 6778 7416

07018

1. PLACE OF DEATH a. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		a. STATE Md b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Harford Grace		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Harford Memorial		d. STREET ADDRESS		136 Osborn e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Lillian	Middle Elizabeth	Last Stevens	4. DATE OF DEATH	Month 5	Day 15 Year 1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		Unknown		Baltimore, Maryland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		2916 New York Ave. Pearl Hutchinson, Baltimore, Md.	
No							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 18 hours					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pulmonary edema, acute					
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Myocardial infarction DUE TO (c)					
DUE TO		Unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
5/17/66							
21. I certify that (I) (this hospital) attended the deceased from 5/17/66 to 5/17/66, that (I) (we) last saw the deceased alive on 5/17/66, and that death occurred at 8 P.M., from the causes and on the date stated above.							
22a. SIGNATURE		22b. DATE SIGNED 5/17/66					
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS					
A.W. GRIGOLEIT		5/17/66 HAILE De GRACE, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)	
Burial		18 May 66		Spesutia Cemetery		Perryman, Maryland	
24. FUNERAL DIRECTOR		Tarring & Son Funeral Home		25a. DATE OF REGISTRATION		25b. REGISTRAR'S SIGNATURE	
John W. McCumber Sr.		Aberdeen, Maryland		5/17/66		Charles Judge	

deafness, or could be

seen

all night

morning

around

1000 feet off the ground

completely around the forest

and

the day

the birds were still flying around the forest

and the birds were still flying around the forest

and the birds were still flying around the forest

and the birds were still flying around the forest

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and the birds were still flying around the forest

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

07028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07019

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE								
Harford MARYLAND		Maryland b. COUNTY Harford								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb DOA								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Aberdeen Route #3								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First JOHN	Middle T.							
4. DECEASED SEX		Last STOUT JR.	Month May							
5. SEX Male		Day 4	Year 1966							
6. COLOR OR RACE White		6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH Jan. 5, 1959	9. AGE (In years lost birthday) 7 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John T. Stout Sr.		14. MOTHER'S MAIDEN NAME Gladys Nelson								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Father, Same as 2 c & d		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 850 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		OUE TO (b) OUE TO (c)		Aphixia due to Drowning		INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall off a log "boat" into pool		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour 4:00 p.m. 5-4-1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Aberdeen Ha Md.		(City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 5-5-66			
ACTUAL SIGNATURE Gerald C. Palmer		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.							Address (Street, city, town, or county) Bel Air, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 6 May 1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Memorial Cemetery St Petersburg, Fla.		23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR Otto Leeser, Jr.		Tarring Funeral Home Aberdeen, Md.		25a. REC'D BY REGISTRAR MAY 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

General book in India

On the first page of the book

General book

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07025

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)																	
Harford		Harford Grace		7 days		a. STATE Md																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Harford																	
Harford Memorial		7 days		Bel Air		12-1																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?																			
Harford Memorial		30 Idlewild St.		YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year															
John Andrew Suite					5	5	3	1966															
5. SEX		6. COLOR OR RACE	7. MARRIED	1 NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS.															
M		W	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	JUNE 18, 1917	48 yrs.	Months	Days	Hours	Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY														
LINEMAN (Trouble)			GAS & Electric Co.			Virginia			U.S.A.														
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME																					
John Andrew Suite		Cora Lee Pitkins																					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address																	
No		215-16-0518		Mrs. MAE E. Suite		30 Idlewild Street Bel Air, Maryland 21014																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											INTERVAL BETWEEN ONSET AND DEATH												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											5 days												
585x Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.											DUE TO (b)	Toxic Nephrosis, Electrolyte Imbalance											5 days
DUE TO (c)											Post Operative Empyema of the gallbladder-cholecystectomy											7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)																					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)													
19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>																					
21. I certify that (I) (this hospital) attended the deceased from 19, to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 6 P.M. from the causes and on the date stated above.																							
22a. SIGNATURE													22b. DATE SIGNED										
22c. PHYSICIAN'S NAME (Type)		M.D.		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		5/14/66													
H. Sadowsky																							
H. Sadowsky		22d. ADDRESS		504 Lewis St. Harford Co. Maryland 21014																			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)															
Burial		May 6, 1966		Bel Air Memorial Gardens		Bel Air, Harford Co. Maryland 21014																	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Joseph William Foster		W. Broadway & Williams		MAY 6 1966		Charles Judge																	
Bel Air, Maryland 21014																							

AP 10161 2002

Planned 2002 (short) Unplanned

FEW-400 (2-1)

1015-2002-0001-0001

2002-3-0001 8120-3-215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07030

CERTIFICATE OF DEATH

07021

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		e. IS RESIDENCE ON A FARM? 12-1 610 Aspen Lane, Edgewood Meadows YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Robert	Middle Lewis	Last Swann
4. DATE OF DEATH May 25 1966	Month Day Year		
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1927
9. AGE (In years last birthday) 38 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturing engineer		11b. KIND OF BUSINESS OR INDUSTRY aircraft	
11. BIRTHPLACE (County & State, or foreign country) Russell Co., Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert F. Swann		14. MOTHER'S MAIDEN NAME Pearl Coffee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WWII	17. INFORMANT Mrs. June P. Swann, 610 Aspen Lane, Edgewood	Address Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 4201 OUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ OUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>5/14</i> , 1966, to <i>5/25</i> , 1966, that (I) (we) last saw the deceased alive on <i>5/25</i> , 1966, and that death occurred at 1 PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>E. Louis Kahan</i>		22b. DATE SIGNED <i>5/25/66</i>	
22c. PHYSICIAN'S NAME (Type) E. Louis Kahan, M.D.,	22d. ADDRESS Edgewood, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF May 25, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hamlett-Dobson F.H.	23d. LOCATION (City, town or county) (State) Kingsport, Sullivan Co., Tenn
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009	ADDRESS	25a. REC'D BY REGISTRAR MAY 26 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07037

07022

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE D.O.A.		c. LENGTH OF STAY IN 1b MARYLAND	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		d. STREET ADDRESS 604 LINWOOD AVE	
3. NAME OF DECEASED (Type or print) IRMA		First I	Middle R
4. DATE OF DEATH May 10 1966		Last W	Month May
5. SEX Female		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-23-1908		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHRISTOPHER J. GOLDBECK		14. MOTHER'S MAIDEN NAME BERTHA BURTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Bertha Buffing - 604 Linwood Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. Death was caused by: IMMEDIATE CAUSE (a) <i>Chronic & Heart Disease -</i> 410x Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>enlarged heart. mitral insuff.</i> (c) <i>regurgitation & Grade IV failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. May 10 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from May 10 1966 to May 10 1966 , that (I) (we) last saw the deceased alive on May 10 1966 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Donald W. Mintzer		22b. DATE SIGNED 5/11/66	
22a. PHYSICIAN'S NAME (Type) Donald W. Mintzer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 3009 EVERGREEN AVE Bldg 14
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-14-66	23c. NAME OF CEMETERY OR CREMATORIAL OAK LAWN CEM.
24. FUNERAL DIRECTOR Hartley Miller, 2334 Jefferson St.		ADDRESS —	25a. REC'D BY REGISTRAR MAY 13 1966
		25b. REGISTRAR'S SIGNATURE —	DATE —

bottom
soil and small
water leaves bottom
on wall ~~water~~ = small
w plants

1 M
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07032

CERTIFICATE OF DEATH

07023

1. PLACE OF DEATH
a. COUNTY

Harford MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

Aberdeen Proving Ground

DOA -

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Kirk Army Hospital

3. NAME OF
DECEASED
(Type or print)

First
Michael

Middle
Gunnar

Last
Wilcut

4. DATE
OF
DEATH

Month
May

Day
17
19
Year
66

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

Male

White

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

N/A

N/A

8. DATE OF BIRTH

9. AGE (in years last birthday)

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

March 18 1966

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29

13. FATHER'S NAME

Donald Wilcut

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

N/A

17. INFORMANT

Hospital Birth Certificate

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

7730
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES NO

2 MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

20d. INJURY OCCURRED

While Not While

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

10:45 a.m.

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17 May 1966

17 May 19

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

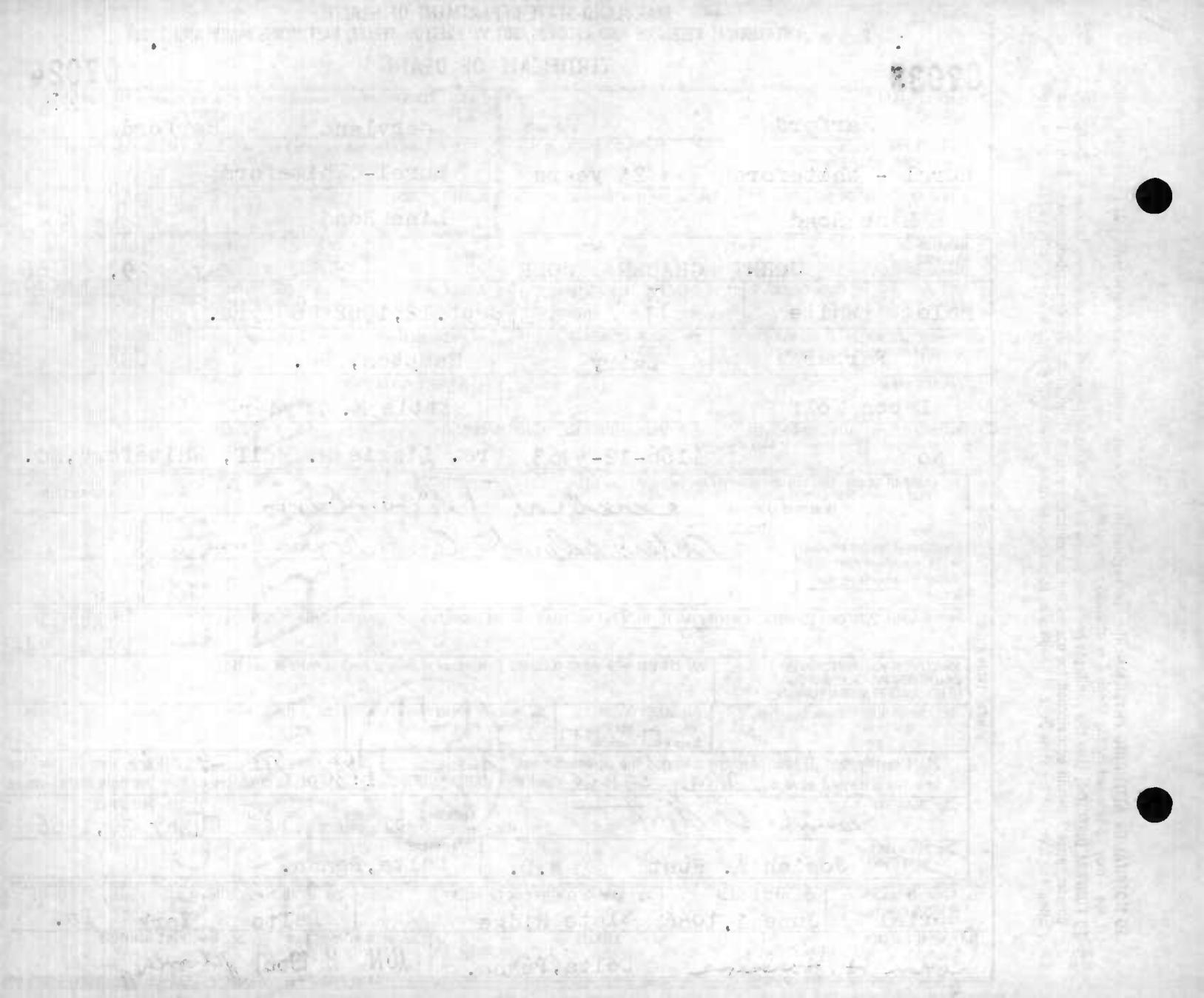
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07033

CERTIFICATE OF DEATH

07024

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Whiteford		c. LENGTH OF STAY IN lb 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Whiteford		12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Line Road				d. STREET ADDRESS Line Road			
3. NAME OF DECEASED (Type or print)		First JOHN	Middle GRADEN	Lost WOLF	4. DATE OF DEATH May 29, 1966		Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1902		9. AGE (In years last birthday) 63 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (County & State, or foreign country) Hampton, Pa.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Labon Wolf				14. MOTHER'S MAIDEN NAME Ettie M. Snyder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 166-12-5963		17. INFORMANT Mrs. Lizzie M. Wolf, Whiteford, Md.		
Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior Sclerotic Cerebral Disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Delta		20f. (City or town) (County) (State) Delta, Penna.	
21. I certify that (I) (this hospital) attended the deceased from Jan 1966 to May 29, 1966 , that (I) (we) last saw the deceased alive on May 29, 1966 , and that death occurred at 1:30 PM , from causes and on the date stated above.							
22a. SIGNATURE Josiah A. Hunt				22b. DATE SIGNED May 30, 1966			
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 1, 1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Slate Ridge	
24. FUNERAL DIRECTOR John H. Hardins				23d. LOCATION (City or Town) (County) (State) Delta, York, Pa.		25a. REC'D BY REGISTRAR DATE JUN 2 1966	
						25b. REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07034 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07025

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>Maryland</i>	2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) b. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> <i>Maryland</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> <i>Maryland</i> 12-1				
d. LENGTH OF STAY IN 1b <i>1 year</i>	d. STREET ADDRESS <i>712 S Union Ave.</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>712 S Union Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Catherine Baekley</i>	4. DATE OF DEATH Month Day Year <i>5/26/66</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/26/1906</i>	9. AGE (In years less birthday) <i>59 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George H. Baekley</i>	14. MOTHER'S MAIDEN NAME <i>Nellie Boyd.</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>4281</i>	17. INFORMANT <i>Unknown</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Arterio sclerotic C V Disease</i>					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>George C. Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bell</i> nd M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>5 - 30 - 66</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>6/1/66</i>		23b. DATE THEREOF <i>6/1/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Engel Hall</i>	23d. LOCATION (City, town or county) <i>Baltimore, Md.</i>	(State)
24. FUNERAL DIRECTOR <i>Washington Rm</i>		ADDRESS <i>Baltimore, Md.</i>	25a. REC'D BY REGISTRAR DUN 1 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07035

CERTIFICATE OF DEATH

07026

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		c. LENGTH OF STAY IN 1b -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		d. STREET ADDRESS P. O. Box 362 Access & Old Point Rd.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alex		First	Middle	Lost	4. DATE OF DEATH	Month	Doy	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 March 1898	9. AGE (In years last birthday) 83 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (County & State, or foreign country) Warsaw, Poland		12. CITIZEN OF WHAT COUNTRY? Unknown			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wgr or dotes of service) 1925 Yes 1955		16. SOCIAL SECURITY NO. 310-40-1055		17. INFORMANT Viola F. Zabor (Wife) Same as 2 above		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 1992		DUE TO Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH Unk			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b)		DUE TO Metastatic Carcinoma				Unk			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that (I) <input type="checkbox"/> attended the deceased from 5 May , 19 66 , to 5 May , 19 66 , that (I) <input type="checkbox"/> last saw the deceased alive on DOA 5 May 19 66 , and that death occurred at 345A M, from causes and on the date stated above.									
22o. SIGNATURE <i>Harold C Sheaffer Cpt</i>									
22c. PHYSICIAN'S NAME (Type) <i>Harold C Sheaffer Cpt</i>		22d. ADDRESS Kirk Army Hospital, AFG, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11 May 66		23c. NAME OF CEMETERY OR CEMINATORY Baltimore National		23d. LOCATION (City or Town) Baltimore Co., Md.		(County) (State)	
24. FUNERAL DIRECTOR <i>Walter W. Linder Jr.</i>		ADDRESS Tarring Funeral Home Aberdeen, Maryland		25a. REC'D. BY REGISTRAR 11 1966		25b. REGISTRAR'S SIGNATURE <i>James J. Jager</i>			

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